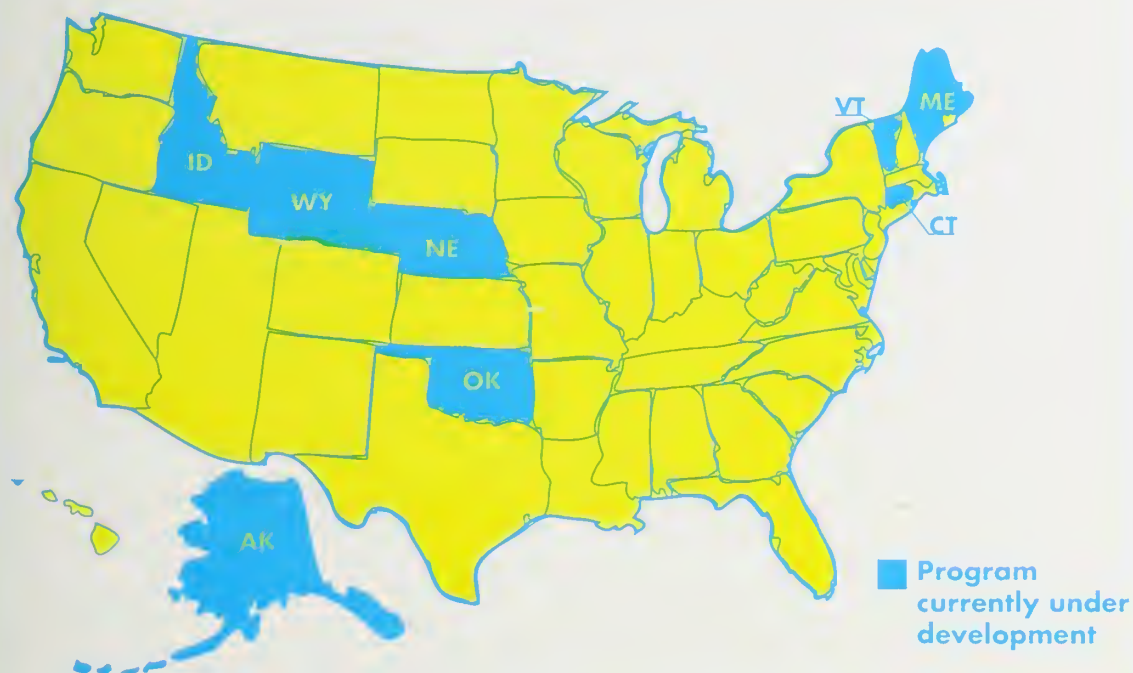


NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS

STATES WITH MEDICAID MANAGED CARE PROGRAMS



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Medicaid Bureau
June 30, 1993

**For Additional Information
Contact**

MEDICAID MANAGED CARE OFFICE

(410) 966-9510

The Medicaid Bureau wishes to thank Carole Benner for her assistance in compiling the attached data.

ALABAMA	1
ALASKA	4
ARIZONA	4
CALIFORNIA	9
COLORADO	12
CONNECTICUT	15
DELAWARE	15
DISTRICT OF COLUMBIA	15
FLORIDA	16
GEORGIA	18
HAWAII.	19
ILLINOIS.	20
INDIANA	24
IOWA	26
KANSAS	28
KENTUCKY	29
LOUISIANA	30
MAINE	31
MARYLAND	32
MASSACHUSETTS	36
MICHIGAN	39
MINNESOTA	49
MISSISSIPPI	51
MISSOURI	53
MONTANA	56
NEBRASKA	58

NEVADA	58
NEW HAMPSHIRE	59
NEW JERSEY	60
NEW MEXICO	63
NEW YORK	70
NORTH CAROLINA	72
OHIO.	75
OKLAHOMA	77
OREGON	78
PENNSYLVANIA	80
RHODE ISLAND	83
SOUTH CAROLINA	84
SOUTH DAKOTA	91
TENNESSEE	93
TEXAS	95
UTAH	97
VERMONT	102
VIRGINIA	103
WASHINGTON	104
WEST VIRGINIA	106
WISCONSIN	109
WYOMING	111

ALABAMA

The Alabama Medicaid Agency is continuing its efforts to implement a Managed Care System in Jefferson and Shelby counties, and other geographical areas of the State. The Agency is planning to contract with various managed care entities to provide quality health care in a cost effective manner and to increase the accessibility of services. Extended quality assurance reviews will be performed on a random sampling of total enrollees by the Managed Care Quality Assurance Program on an annual basis. There will also be an external review by an independent PRO entity.

The Alabama Medicaid Agency is certain the providing a medical home for our Medicaid beneficiaries will definitely improve the overall health care status of our growing Medicaid population.

CONTACT: Henry W. Davis, III
Director
Managed Care Division
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, AL 36130
(205) 277-2733
FAX: (205) 270-6995

ALABAMA'S MEDICAID MATERNITY WAIVER PROGRAM

The Alabama Medicaid Maternity Waiver Program (Waiver) was implemented September 1, 1988, pursuant to 1915 (b)(1), (b)(3), and (b)(4) of the Social Security Act (the Act). Specific sections of the Act which were waived were Sections 1902(a)(1) (Statewide effectiveness), 1902(a)(10) (duration, amount, and scope of benefits), and 1902(a)(23) (freedom of choice of providers). These specific waivers are necessary because the waiver program is being phased in on a statewide basis because additional services are offered to waiver women and because the recipient's freedom of choice is restricted to a primary provider.

The waiver provides for a coordinated, comprehensive case managed system by which women receive all services necessary for a health pregnancy. High risk women are targeted early and referred to specialty physicians for care for their special needs. Approximately 35,000 recipients in 42 counties have received care through the waiver since September 1988. In addition to prenatal care, women receive information about nutritional services (WIC), family planning services, EPSDT services, and post partum care. All care for the pregnant woman is coordinated through the primary provider. The primary provider for an area is responsible for establishing a network of subcontractors to provide a total system of obstetrical care.

The waiver has been judged to be successful in three area: Access to Care and Quality of Services; Impact of the Program; and Cost Effectiveness. Below is specific information about successes we have had.

A. PRENATAL VISITS/WEEKS GESTATION

The main objective of the Maternity Waiver Program is to get women into the care system early and to provide continuous and comprehensive prenatal care in an effort to produce better birth outcomes. Prior to the waiver, claims data indicated that women received an average of three prenatal visits. Since 1988, women participating in the waiver received an average of nine visits.

Though maternity services are available in non-waiver counties, they are fragmented. The difference in waiver counties is that there is a care coordinator who is responsible for coordinating all services through an established provider network ensuring that women make and keep all appointments. In addition, the care coordinator is a contact person for the recipient and lets the recipient know that someone does care. The provider network contains all the requisite services needed and is monitored continually for appropriateness in terms of quality of and access to care.

B. VAGINAL VS C-SECTION BIRTH RATES

The costs associated with caesarean births are higher than vaginal birth costs. In waiver counties, the number of C-section births per 100 deliveries is lower than in non-waiver counties. Since implementation of the waiver program, there has been a difference of approximately 6.3%. A reduction in C-section births can also be indicative of adequate and quality prenatal care.

C. DIAGNOSTIC TESTINGS

Cost savings are being realized in the area of diagnostic testings. In non-waiver counties, prenatal care is fragmented and often times a woman will see numerous providers. Each time a woman visits a new physician, a variety of tests are performed, often repeating those already done. In the waiver, however, women are required to coordinate all phases of care through a care coordinator thereby eliminating duplication of services. Recipients in non-waiver counties receive an average of 180 tests per 100 deliveries (9/90-12/91) compared to 129 tests per 100 deliveries for waiver recipients. The savings associated with reduced testings are substantial in that on average \$1700 more per 100 deliveries is spent on testing in non-waiver counties as in waiver counties.

D. HOSPITAL READMISSIONS DURING THE FIRST YEAR OF LIFE

Babies born healthier are less likely to become sick during their first year of life. By producing healthier babies at birth through the waiver, we are offsetting costly medical services during their first year of life.

E. NICU

Our data indicates that the majority of NICU stays are for premature babies. If we can prevent just one birth complication which carries with it a lifetime of costly medical care, then the waiver program can be considered a success. On average, babies born to waiver recipients receive 11 NICU days compared to 14 NICU days for non-waiver babies.

Not only is medical care provided through the waiver, but this care is augmented with care coordination (case management) and home visitation. One key to the success of the waiver program is the care coordinator. The care coordinator is responsible for coordinating all phases of the woman's care, ensuring that all appointments are kept, coordinating referrals to specialty physicians when appropriate, making arrangements for delivery (including availability of transportation), arranging for the home visit, and performing many other duties as enumerated in the care coordinator manual. An additional duty of the care coordinator is to educate the pregnant woman/new mother of the importance of medical care for the newborn. Enrollment into the EPSDT Program is encouraged and connection with pediatricians can be made if requested. The providers agree that the care coordinator approach has improved the pregnant woman's understanding of the importance of adequate prenatal care. According to the client evaluation survey conducted by the independent assessor, waiver program clients were significantly more likely to see care coordinators or social workers, to receive health education, counseling about social services and help with transportation than clients in non-waiver areas.

All of these services are paid for through an expanded global fee which is paid to the primary provider. The primary provider in turn reimburses it's subcontractors a negotiated rate for the services performed. The expanded fee is set at 97% of the fee-

for-services reimbursement which is an immediate cost savings. Since 1988, it has been determined that approximately 4 million dollars have been saved because of the program.

CONTACT: Kim B. Davis, Associate Director
Maternity Waiver Program
Alabama Medicaid Agency
2500 Fairlane Drive
P.O. Box 244201
Montgomery, AL 36124-4201
(205) 277-2710
FAX: (205) 270-1876

ALASKA

Alaska currently does have any managed care programs in operation at this time.

CONTACT: Kimberly B. Busch, Director
Department of Health and Social Services
P.O. Box 110660
Juneau, Alaska
(907) 465-3355

ARIZONA

The Arizona Health Care Cost Containment System (AHCCCS) is in its 11th year of operation as a Medicaid 1115 research and demonstration project. The program began October 1, 1982, and is now serving more than 472,000 persons: 417,234 Medicaid members and 54,766 persons funded with state-only dollars. Included in the total are 17,470 people who have qualified for services under the Arizona Long Term Care System, a major program that started in January 1989 for persons with developmental disabilities and the elderly and physically disabled.

Before 1982, Arizona was the only State not participating in the federal Medicaid program, which began in the mid-1960s. In the spring of 1982, AHCCCS was approved as a three-year demonstration project (under section 1115 of the Social Security Act (the Act)) by the Health Care Financing Administration (HCFA), the federal agency that oversees the program. AHCCCS officially began October 1, 1982. HCFA has since given the program repeated extensions to continue operating and receiving federal funds as a demonstration project. In late November 1988, HCFA approved a five-year extension until 1993, and in late 1992 HCFA approved another extension: until September 30, 1994. A significant challenge for Arizona will be to gain permanency for AHCCCS when the current 1115 waiver expires.

The goal of the AHCCCS project was to develop and test a new

delivery and payment system for providing health care services, to facilitate cost containment, improve patient access and, at the same time, deliver quality care.

The original program design called for a private contractor to serve as the day-to-day administrator. The administrator's responsibilities included: enrollment functions, health plan oversight, audit and compliance functions, claims processing, medical quality assurance, and grievance and appeals. The program was implemented with very little time for planning and development. Virtually every review of the early years of AHCCCS cites an inadequate amount of time for planning.

During its first 18 months the program was beset with a number of administrative and budgetary problems, which resulted in the termination of the private administrator's contract less than halfway through the contracted term. There was a tremendous amount of negative press about the program, creating a lack of confidence among elected officials, the medical community and the public at large.

After having received a notice of contract termination from the private administrator in March 1984, the state assumed the administration of the program. A task force was appointed to manage the transition from the private sector to the State.

Within 30 days, the State successfully took over the operation. It hired 150 employees, transferred the private administrator's computer software system to state computers, and brought on-line a new computer center.

The AHCCCS program was mobilized to assume a strong, regulatory position. New challenges included:

- o Performing financial and contractual compliance reviews of 19 contracting health plans;
- o Quality control review of the county eligibility systems;
- o Medical quality-of-care audits of the health plans, some of the most thorough medical reviews of any Medicaid program; and
- o Increased staffing for the audits, compliance and utilization review functions.

After the State assumed administration of the program, two health plan contracts were terminated due to plan insolvency and another plan with new management was successfully reorganized under the federal bankruptcy statutes. AHCCCS was then, and remains today, the only statewide prepaid Medicaid system in the country.

Funding. AHCCCS is funded by a combination of State, county and federal contributions. One difference between AHCCCS and traditional Medicaid is that AHCCCS funds prepaid health plans on a capitated basis, (fixed rates based on AHCCCS population numbers) rather than a traditional fee-for-service arrangement based on services rendered.

Eligibility Groups. AHCCCS provides services to several different groups of people. These include:

- o Categorical individuals who enter AHCCCS through a program for which federal matching funds are available. Examples are persons who are receiving Aid to Families with Dependent Children (through the Department of Economic Security) or Supplemental Security Income (through the Social Security Administration);
- o Sixth Omnibus Budget Reconciliation Act (SOBRA) mothers and children, (January 1, 1988);
- o Persons up to 300 percent of the Supplemental Security Income who need long term care services (January 1, 1989); and,
- o 100 percent state-funded population known as medically need/medically indigent (MN/MI).

The number of eligibles in AHCCCS has grown significantly since the beginning of the program. At the end of the first program year in September 1983, there were approximately 160,000 members. As of June 1, 1993, AHCCCS had 472,193 members. The current number of Medicaid eligible members are: 17,470 long-term care recipients, 278,658 AFDC/SSI/Medical Assistance Only members, and 101,636 SOBRA women and children. In the State-funded program, there are 54,766 persons: 49,563 MN/MI and 5,203 eligible low-income children.

Covered Services. Services covered by AHCCCS include:

- o Inpatient hospital services
- o Outpatient health services
- o Laboratory and x-ray services
- o Pharmacy services
- o Medical supplies, medical equipment, and prosthetic devices
- o Emergency ambulance and medically necessary transportation
- o Emergency dental care and extractions for adults
- o Medically necessary dentures
- o Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under the age of 21

- o Certain oral surgery for children under the age of 21 as of October 1, 1985
- o Podiatry services as of October 1, 1985
- o Medically necessary transplants that include: kidney, cornea and bone transplants and immuno-suppressant medications (available to all populations under AHCCCS); as of October 1, 1987, heart transplants for categorical members only; as of October 1, 1988, liver transplants for categorically eligible children; as of October 1, 1989, autologous bone marrow transplants for categorical members; and, in 1991 allogenic bone marrow transplants
- o Family planning services as of October 1, 1988
- o Home health care services as of January 1989
- o Behavioral health services for children under the age of 21 as of April 1, 1991
- o Long term care and home and community based services for physically disabled/elderly and developmentally disabled as of January 1989
- o Private duty nursing services
- o Rural health clinic services
- o Federally qualified health center services
- o Therapy services
- o Nurse midwife services
- o Hospice services
- o Respiratory care services
- o As of November 1, 1992, mental health services for adults who are seriously mentally ill.

Service Delivery. Services are provided to eligible populations through health plans that are selected by competitive bidding. Bids are awarded on a county-by-county basis. Enrollment in a prepaid health plan is mandatory for all members except American Indians, who may choose either a health plan or the Indian Health Service as a provider of medical care. AHCCCS has contracts with 14 health plans statewide which are reimbursed on a prepaid capitated basis. All counties currently are being serviced by at least one health plan.

AHCCCS also has a fee-for-service exposure, which occurs when a person is first declared eligible but has not yet joined a health plan. AHCCCS pays non-hospital providers directly based on a maximum allowable charge set by the AHCCCS Administration. Hospitals are reimbursed based on a new per-diem, tiered system of reimbursement. The new system replaced the former adjusted billed charges method and is different because it is based on actual costs, not on predetermined charges.

Quality of Care. Documenting quality health care delivery has proved difficult in a prepaid setting. There are a few such measuring sticks in the private sector, and this led AHCCCS to develop a system of its own. This system is based on audits

performed annually by out-of-state physicians who examine AHCCCS patient records maintained by primary care physicians.

Medical quality of care audits have been conducted annually and indicate that care for AHCCCS members is being provided within generally accepted medical practice criteria. These audits also indicate that AHCCCS members are being mainstreamed into the general health care delivery system. This mainstreaming is evidenced by the fact that approximately 70 percent of Arizona's licensed physicians (MDs and DOs) are registered with AHCCCS, either through its fee-for-service component or its prepaid component.

Increases to the AHCCCS health plans were held to under 5 percent for the current contract period. Compared to the private sector industry, AHCCCS typically treats sicker clients; however, medical cost increases have been substantially less compared to private carriers.

While AHCCCS is still a relatively new program and is paralleling the usual steps that accompany organizational evolution, considerable progress has been made. Costs have been controlled without a reduction in quality and a system has been developed to assess and monitor quality health care. For the first time, federal funds have been brought into the State for indigent health care. The health plans are maturing and continue to develop creative contractual arrangements with the direct providers of care. Elements of competition and risk-sharing have been introduced into the indigent health care delivery system. Members have been given access to mainstream medical care.

Perhaps of equal importance, a program has been developed that can be used by other States to implement a prepaid, managed health care program without the pitfalls AHCCCS encountered in its early stages of development.

SRI International Evaluation of AHCCCS - January 1989. The summary of their findings are as follows:

- o Cost: Over the programs's first five years, the average per capita costs for AHCCCS increased at a rate of 23.1 percent while those for traditional Medicaid increased 37.3 percent.
- o Utilization: Hospital utilization under AHCCCS was lower than traditional Medicaid and indicated a significant savings.
- o Quality of Care: Care for children under AHCCCS was in greater conformance with generally accepted guidelines from the American Association of Pediatrics.

- o Access and Satisfaction: Even though beneficiaries reported some problems with access to emergency care, access to routine care was better under AHCCCS and absolute satisfaction levels were high.
- o In addition,..AHCCCS "probably does more than any other state Medicaid program" in the area of quality assurance.

CONTACT: Frank Lopez, Public Information Office
Office of the Director
AHCCCS - mail drop 4100
P.O. Box 25520
Phoenix, AZ 85002
(602) 234-3655, ext. 4161

CALIFORNIA

The managed care program in California's Medi-Cal Program initially was established to save Medi-Cal Program expenditures, as capitation rates are by law set at fee-for-service (FFS) cost equivalence or less. Through the evolutionary process of refining managed care programs, it has become evident that the more efficient FFS Medi-Cal becomes the less money is saved through managed care programs because the managed care capitation rates become correspondingly lower. While managed care programs continue to save funds, the true benefit of managed care is realized through enhancement of access to medical care, particularly primary care and preventive services, for Medi-Cal managed care members and alleviation of the administrative burden on Medi-Cal providers imposed by the FFS Medi-Cal system.

Anticipated Program Expansion

The State of California is currently undertaking a broad and ambitious task to implement a plan to address both the increasing costs to the State and declining practicality of FFS Medi-Cal (California's Medicaid program) for both providers and beneficiaries by developing a managed care initiative. The goal of this initiative is to assure that there are medical professionals available to provide medically necessary services in all areas of the State. The initiative proposes fundamental changes in the Medi-Cal delivery system. These proposed changes may generally be categorized into one of the four following areas:

- o Expansion of capitated systems to include up to 50 percent more Medi-Cal population (approximately 2.5 million people) into managed care arrangements.

- o Development of programs tailored for the needs of the State's elderly population.
- o Creation of a FFS managed care program where FFS providers have an incentive to control utilization in selected areas of the State, where there is little or no managed care plan penetration existing or expected.
- o Stabilization of Medi-Cal managed care plan enrollment through mandatory enrollment programs and restricted disenrollment periods.

The managed care initiative includes three key components. The most significant is the development of a two-plan managed care model in 13 of the State's more populous counties. Full implementation is planned for fiscal year 1995-96. The two plan model will involve mandatory enrollment of most Medi-Cal beneficiaries in a county in their choice of a commercial health maintenance organization (HMO) selected by the State through a competitive bidding process or a "local initiative", a county government based HMO. The second component will be the expansion of the State's county organized health system concept into three additional counties , as authorized by OBRA '90. The new counties will be phased in, with the first program scheduled to begin operation in early 1994. The third component will be the Geographic Managed Care (GMC) pilot project, a model involving mandatory enrollment of most Medi-Cal beneficiaries in a county in their choice of several fully capitated HMOs or in Primary Care Case Management (PCCM) plans, which are partially capitated clinic-based providers. The GMC pilot project is scheduled for implementation in January 1994. Federal waivers are required for each of these programs; the waiver for the GMC pilot project has been submitted; work on the other waiver requests is in progress.

Current Coordinated Care Programs

Prepaid Health Plans (PHPs)/HMOs. California, through its Department of Health Services (DHS), currently contracts with 10 PHPs that provide most Medi-Cal health care benefits. Enrollees agree to receive all contracted care through the plan and are entitled to access to a defined set of benefits and services guaranteed by the plan. In exchange for capitation fees, the PHP assumes the risk of the costs of covered services. Enrollment in PHPs is voluntary within covered categories (cash grant, medically needy, and SSI/SSP), and disenrollment is granted on demand. Areas of enrollment for PHPs are concentrated in Southern California, with Los Angeles County and San Diego County representing approximately 75 percent of the PHP population. Current enrollment in PHPs is approximately 373,000.

Primary Care Case Management (PCCM) Plans. The PCCM Program, which now includes 18 contractors, provides a means for Medi-Cal primary care providers to participate in a capitated program without having to qualify as a PHP/HMO. The primary differences between a PHP and a PCCM plan are the scope of capitated services, medical services authorization requirements, and the reimbursement mechanism for providers. PCCM plans are at risk and receive payments for outpatient services only. Inpatient services and medical services for which the PCCM plan has not elected to be at risk are covered under the FFS program with prior authorization by the PCCM plan. PCCM plans also participate in "Savings Sharing", wherein the State splits any savings with the plans on a 50-50 basis. The Savings Share is based on the difference between the actual FFS health care costs of noncapitated services authorized by a PCCM plan and an actuarial estimate of the costs that would have been incurred had the enrollees been covered by the FFS program.

Enrollment in PCCM plans is voluntary within covered categories (cash grant, medically needy, and SSI/SSP), and disenrollment is granted on demand. Areas of enrollment for PCCM plans are also concentrated in Southern California; the majority of enrollees are in Los Angeles County. Current enrollment in PCCM plans is 228,000.

County Organized Health Systems/Health Insuring Organizations (HIOs). California also contracts with two HIOs, one in Santa Barbara County and another in San Mateo County. Under these contracts, almost all Medi-Cal eligibles in each county either choose or are assigned to a primary care physician who case manages the enrollee. Again, the HIO assumes the risk of covered medical services for a set capitation fee. Primary care providers (PCPs) in HIO counties have an opportunity to share in program savings which are created by efficient control of health care utilization. If the utilization of assigned patients exceeds projections, no savings are available for sharing with the physicians. Cost overruns are not, however, passed on to the provider.

Enrollment in HIOs is mandatory for covered categories. Current enrollment is approximately 37,500 for Santa Barbara and approximately 41,200 for San Mateo.

PHPs, PCCM plans, and HIOs also may elect a contractually determined risk ceiling, with costs beyond that ceiling being reimbursed to the plan by the State at FFS Medi-Cal rates.

Other Coordinated Care Programs. California also operates coordinated care programs for the elderly, one of which is Senior Care Action Network (SCAN), a Social Health Maintenance Organization (S/HMO), with an enrollment of about 360. The others are On Lok Health Services, the senior prototype of the

Program of All-Inclusive Care for the Elderly (PACE) with an enrollment of about 350, and two programs in process of securing full PACE status with enrollment of about 110. All these programs are demonstration projects under section 1115 of the Social Security Act.

On Lok's primary goal is to keep the frail elderly in their homes, living as independently as possible, for as long as it is appropriate. The State projects to have a total of 5 OnLok replications (PACE projects); two have been implemented. On Lok operates in San Francisco county; the two new projects operate in Sacramento and Alameda counties. SCAN is in Los Angeles and Orange Counties. SCAN's primary goal is the same as On Lok's, with the major difference being that the independent provider network in SCAN acts as a broker of social and health care services. Both On Lok and SCAN enrollees must meet age requirements, but On Lok and the two PACE projects cover long term and life care, while SCAN does not.

In early 1993, under new statutory requirements, the State will initiate an aggressive program of intensive medical case management, aimed at Medi-Cal beneficiaries with predictably high medical costs, such as the chronically or catastrophically ill using State staff and private case management contractors. The program will assure that appropriate rehabilitation and treatment services are identified early and are provided in a planned and coordinated manner. Cost-effective outpatient therapies will be used as alternatives to extended or recurrent hospitalizations.

The Family Mosaic Project began accepting enrollments in June 1993. This project is a contract between California and San Francisco City and County to provide mental health services under capitation to severely emotionally disturbed children at risk for out-of-home placement.

CONTACT: Joseph A Kelly, Kenneth J. Wagstaff
State of California - Health and Welfare Agency
Department of Health Services
Medi-Cal Managed Care Division
714 P Street, Room 650
P.O. Box 942732
Sacramento, CA 94232-7320
(916) 657-0025

COLORADO

Current Coordinated Care Programs

HMOs. The State of Colorado currently has one HMO actively providing services to Medicaid enrollees. The HMO is Federally qualified. There are no PHPs or HIOs.

Colorado also has a PACE demonstration model which is a replication of the California "On Lok" program. The PACE demonstration model is expanding to a second site August 1993.

Enrollment into Colorado's HMO program is voluntary and available to all categories of assistance. Colorado has contracted with HMOs on a prepaid capitated basis since 1974.

o Rocky Mountain HMO (RMHMO) based in Grand Junction, Colorado, has been a Medicaid HMO since 1974. RMHMO serves Medicaid enrollees in Mesa, Montrose, Delta, and Rio Blanco counties on the Western Slope. Medicaid enrollment was 8,643 as of May 1993, which represents 59.40 percent of the Medicaid population in those counties.

In 1988, Colorado developed its HMO Monitoring and Review program in an effort to assure that a contracting HMO provides quality care to all enrolled Medicaid clients.

There are three components of the monitoring and review process: 1) professional assessment covering quality assurance and peer review; 2) technical assessment concentrating on contractual compliance and licensing review; and 3) client services assessment accomplished through client surveys.

The professional assessment review is conducted by the Colorado Peer Review Organization: the Colorado Foundation for Medical Care (CFMC). CFMC analyzes the internal quality assurance programs of the Medicaid HMOs. These are conducted yearly through Colorado's contract with CFMC. CFMC submits annual reports of their findings to the Department and to the HMOs.

CONTACT: Ms. Donna Marshall, Manager
HMO/Capitation Section
Department of Social Services
1575 Sherman Street
5th Floor
Denver, CO 80203-1714
(303) 866-3163

Primary Care Physician Program (PCPP). Colorado's Medicaid PCPP was implemented statewide in 1983 as one of the first primary care case management programs operating under a §1915(b) freedom of choice waiver. Participation in the PCPP is mandatory for all Medicaid recipients unless a recipient resides in an HMO county, whereby the HMO would be an alternative to the PCPP. The other exception to participation in the PCPP is if the recipient is either a Medicare/Medicaid recipient or in the Colorado Foster Care program.

The PCPP is a physician-based program which focuses on the physician as the gatekeeper for Medicaid benefits. The primary care physician (PCP) is selected by eligible recipients. The physician has overall responsibility and accountability for the level, scope, and quality of care provided to the PCP's Medicaid patients. The PCP is responsible for providing primary care services, coordinating the provision of other necessary medical/health care, and monitoring utilization of Medicaid services by his/her patients. A referral is required from the PCP to other providers of care, except for the following exempted services:

- o emergency care services
- o community mental health services
- o psychiatric/psychological services
- o family planning services
- o podiatry services
- o dental/vision services under EPSDT program
- o transportation services
- o anesthesia services
- o laboratory/radiology services
- o pharmacy services
- o child abuse victim related services
- o pregnancy-related services

Independent program evaluations conducted in 1984, 1986, 1988, and 1991 have consistently concluded that the PCPP has been successful in reducing emergency room usage as a primary care setting, improving physician participation and patient access to care, and in realizing significant cost savings. Clients have reported satisfaction with the program in surveys conducted for each evaluation study. Physicians in Colorado continue to view this program as a joint initiative between them and the State, and continue their support by participating as PCPs. In June 1993, implementation of an automated telephone information system for both clients and providers was completed and provides general information to frequently asked questions and access to physician referral lists.

Current participation is approximately 117,140 recipients or 47.1% of the Medicaid population, with 1,896 participating providers and 22 participating Community Health Clinics.

CONTACT: Donna Allen, Coordinator
Primary Care Physician Program
Department of Social Services
1575 Sherman Street
5th Floor
Denver, CO 80203-1714
(303) 866-2220

CONNECTICUT

Connecticut currently has no managed care contracts.

CONTACT: Linda Schofield, Director
Office of Medicaid Care Administration
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, CT 06106
(203) 566-2934

DELAWARE

Delaware currently has no managed care contracts.

CONTACT: Philip P. Soule, Sr.
Medicaid Director
Division of Social Services
P.O. Box 906/Biggs Building
New Castle, DE 19720

DISTRICT OF COLUMBIA

The District of Columbia Medicaid Program has one coordinated care program, which is its contract with Chartered Health Plan. Chartered enrolls AFDC recipients only at the present time. Enrollment is entirely voluntary on the part of the recipient.

Chartered may enroll recipients regardless of where they live in the District.

Currently, Chartered has approximately 16,000 Medicaid recipients among their members.

CONTACT: Ms. A. Sue Brown, Deputy Commissioner
Commission on Health Care Finance
Department of Human Services
Government of the District of Columbia
Suite 302
2100 Martin Luther King Jr. Avenue, S.E.
Washington, D.C. 20020
(202) 727-0729

The District was recently granted a waiver to implement a managed care program which will be implemented before the end of this fiscal year. The program will be District-wide and will be mandatory for AFDC and AFDC-related recipients.

FLORIDA

Current Coordinated Care Programs

PHPs/HMOs. For the past 12 years the managed care effort in Florida has been primarily focused on PHPs and HMOs. Today there are 14 contracts affecting nearly 274,000 Medicaid recipients in 25 of the 61 counties in the State. Twenty additional applications are under review to provide services to most counties in the State. A new State law requires all commercial HMOs to apply for a Medicaid contract and enroll Medicaid recipients up to at least five percent of their total enrollment. Expectations are that by the end of the current contract year (June 30, 1993) there will be at least 30 contractors and 375,000 enrollees statewide.

Eight of the 14 current prepaid contractors are State certified HMOs. The other five are PHPs, with two being governmental entities and the remaining three State defined HMOs operating with enrollment composition waivers.

Each of the current contractors provides a basic core of services including hospital, physician, prescribed drugs, lab, x-ray, EPSDT, therapies, home health care and durable medical equipment. Optional services include family planning, transportation, adult denture and child dental, hearing, vision and nursing home services. The plans are capitated for all services.

The AFDC related eligible population is served by all contractors. All but four plans also serve the SSI population, both with and without Medicare. Only the SSI eligible group may receive nursing home services on a prepaid risk basis and two contractors have been authorized to cover that optional service to date.

Enrollment and disenrollment in all HMO/PHPs is voluntary from month to month. Internal monitoring is performed by a staff of contract managers by Medicaid field staff. External peer review is performed under contract by a professional review organization (PRO). That review generally includes a statistically significant sample of each contractor's medical records, whether staff or IPA model.

PCCM. Florida also has a PCCM called "MediPass" (Medicaid Physician Access System), authorized under a §1915(b)(1) waiver, which began providing services in four Florida counties in the Tampa/St. Petersburg area on October 1, 1991. Enrollment in

MediPass or an HMO alternative is mandatory. As of June 1, 1993, 87,000 AFDC recipients have enrolled in MediPass.

Primary care physicians (including general and family practitioners, internists, pediatricians, obstetricians, gynecologists, group practices, Federally Qualified Health Centers, rural health clinics and county public health units) receive a monthly \$3 per capita case management fee. They are responsible for providing access to primary care services on a 24 hour, seven days a week basis, and prior authorizing most specialty and hospital care. Services managed by MediPass primary care physicians include hospital, physician, prescribed drugs (when the Rx is written by the primary care physician), lab, x-ray, EPSDT, home health, podiatry, nurse practitioner, ambulatory surgical center and rural health center services. MediPass does not manage mental health, visual or maternity-related services. No prior authorization of those or emergency services is required. Payment for services provided is on a FFS basis. Primary care providers are not at risk for any services, however, continued participation in the program is dependent upon acceptable case management of services.

Evaluation of MediPass has been conducted under contract with the University of South Florida in Tampa. By means of satisfaction surveys, 100 percent of MediPass participating providers and 12 percent of MediPass clients were questioned concerning their access to care and satisfaction with the program. Over 80 percent of the MediPass physicians and over 80 percent of the MediPass clients rated MediPass highly on access to care and general satisfaction. The evaluation found an overall 25.3 percent reduction in the costs of services managed by MediPass physicians. While these savings are probably overstated because this initial evaluation was based on limited data, Medicaid expects MediPass to produce significant savings on a continuous basis.

Following this evaluation and the successful operation of MediPass in the Tampa area, the program will be expanded Statewide in the coming year, so that a managed care choice of MediPass or HMO may be offered to most Medicaid recipients. In addition, Florida Medicaid has received federal approval to develop a prepaid mental health plan project. Florida has also been chosen as a site for the Medicaid Working Group's grant-funded help in developing the State's Title V agency into a Medicaid prepaid health plan for children with special health needs.

Florida Medicaid is implementing a recipient lock-in program designed to promote coordination of care, reduce inappropriate service utilization, and control program expenditures. Clients enrolled in this corrective managed care program are identified as utilizers of services in excess of that which would be

reasonable and appropriate to their medical diagnosis.

A computer program produces reports of individuals whose service utilization patterns suggest misuse. A detailed payment history is reviewed by registered nurses to determine whether the services are medically indicated.

Clients who are determined to be inappropriately utilizing are contacted and given six months to correct their behavior. When overutilization continues, clients are enrolled with a physician case manager who is responsible for providing primary care and authorizing other levels of care. Managing physicians are paid a case management fee plus FFS reimbursement for services rendered.

At the end of one year, the case is reviewed again and restrictions may be lifted or extended, depending on whether the recipient has changed the service utilization pattern leading to corrective management.

CONTACT: Marilyn G. Reeves, Ph.D., Chief
Medicaid Managed Health Care
Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
(904) 922-6830

GEORGIA

The types of managed care programs that are available are limited in scope and are listed below:

- o prenatal case management
- o mental health case management
- o early intervention case management
- o recipient lock-in (for identified aberrant recipients)

The Georgia Access Program - Primary Care Case Management (PCCM). Georgia intends to begin a pilot PCCM program on July 1, 1993. The pilot will begin in six of Georgia's 159 counties and be expanded in a few counties at a time. The Georgia Access Program will be patterned after Kentucky's KenPAC and North Carolina's Carolina Access PCCM programs. Enrollment with an Access Program primary care physician will be mandatory for all Medicaid recipients in the pilot counties. Primary care physicians who choose to serve as case managers for Medicaid recipients will be paid a monthly fee for each Medicaid recipient enrolled with them. As case managers, physicians in the program will authorize their Medicaid recipients' medical care, including referrals to specialists, inpatient and outpatient hospital, laboratory services, etc. All services rendered by Medicaid providers will continue to be paid as fee-for-service.

Pregnant Substance Abuse Day Treatment Program Waiver. This program provides access to treatment of substance abuse during pregnancy and to a coordinated system of health care for the Medicaid mother and child beginning immediately after delivery. Substance abuse, as defined for this program, includes both alcohol and illicit drug use, but does not apply to alcohol abuse only. The Day Treatment service includes a process to integrate and coordinate the substance abuser's pregnancy and infant health care needs into the program. Services are provided a minimum of four hours a day to each recipient.

Precertification of All Hospital Admissions. Precertification of hospital admissions is designed to improve appropriate utilization of services and to control costs. All hospital admissions for Georgia Medicaid recipients are reviewed for medical necessity before admission or within two working days for emergency admissions. The only exceptions are for "normal" delivery, infants less than one year of age, and recipients with Medicare Part A coverage. The overall costs savings for inpatient hospital, outpatient hospital, and physician services, has been in the neighborhood of 8% to 10%, or \$50 million a year.

The Lock-In Program. The lock-in program is a physician case management program designed for aberrant Medicaid recipients who have a pattern of gross misutilization of non-emergency services. Through freedom of choice, the recipient is limited to a single physician and a single pharmacy from which they may receive services. The physician must approve most services for the recipient.

CONTACT: Bill Deck
Director of Planning
State of Georgia, Department of Medical Assistance
Floyd Veterans Memorial Bldg. - West Tower
2 Martin Luther King, Jr. Drive, S.E.
Atlanta, GA 30334
(404) 651-5784

HAWAII

The sole managed care provider in Hawaii is Kaiser Foundation Health Plan, Inc. The service areas are the islands of Oahu and Maui. The catchment or enrollment areas are the islands of Oahu and designated areas of Maui which are within one-half hour of surface travel time to the service site. The option to voluntarily enroll is limited to recipients of AFDC benefits. However, continued HMO coverage is permitted with categorical change, provided benefits are received continuously with no break in service.

The annual independent external review of HMO services as

mandated by OBRA '86 is currently contracted with Alabama Quality Assurance Foundation, Inc., 600 Beacon Parkway West, Suite 600, Birmingham, AL 35209-3154.

The State plans to expand its delivery of medical services through managed care programs to include a more substantial portion of the Medicaid population.

CONTACT: Lillian Murakami
Health Care Administration Division
Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339
(808) 586-5476

ILLINOIS

HEALTHY MOMS/HEALTHY KIDS

The Healthy Moms/Healthy Kids program was implemented Statewide in April 1993 to improve the health of low income families by expanding access to primary care and preventive services.

The goals of the Healthy Moms/Healthy Kids Program are to:

- o support infant mortality reduction efforts;
- o ensure pregnant women and children receive primary health care services;
- o expand quality primary care capacity through incentives;
- o reduce Medicaid expenditures for high-cost, preventable conditions;
- o comply with Federal Medicaid requirements of ensuring that 80 percent of Medicaid children receive appropriate screenings and vaccinations by 1995;
- o meet Federal Medicaid mandates to ensure access to care for pregnant women and children is at least equal to that available to the general population.

The key components include:

- o Rate increases for participating physicians
- o Case management services for pregnant women and children
- o Managed Care for pregnant women and children (City of Chicago)

RATE INCREASES/PHYSICIAN QUALIFICATIONS

Physicians receive enhanced reimbursement for 1) EPSDT services for children through age twenty; 2) risk assessments, and 3)

delivery services provided to pregnant women. These rates are effective April 1, 1993 or with the date of the physician's enrollment into the HM/HK Program, whichever is later. In order for a physician to enroll in the HM/HK program and qualify for the enhanced reimbursement rates, the physician is required to meet specific quality standards and agree to perform certain services, including:

- o Hold hospital privileges;
- o Provide 24-hour telephone coverage;
- o Have arrangements for "sick" children and "at risk" pregnant women to be seen within 24 hours of the request, based on a triage of need;
- o Provide periodic health assessment examination (EPSDT) and primary pediatric care, in accordance with the American Academy of Pediatrics or Academy of Family Physicians for providers serving children;
- o Provide obstetrical care, in accordance with the American College of Obstetricians and Gynecologists or Academy of Family Physicians for providers serving pregnant women;
- o Arrange for any specialty care required for the child or pregnant woman;
- o Coordinate with the case management entity (when applicable) to ensure that needed services are received;
- o Perform risk assessment to assure that appropriate referrals are made when indicated to substance abuse programs, mental health providers, etc.

CITY OF CHICAGO-MANAGED CARE FOR PREGNANT WOMEN AND CHILDREN

Under the authority of a 1915(b) waiver, Medicaid clients who are pregnant women and children (up to age 21) in the city of Chicago must select from one of the following primary health care options under the HM/HK program:

- o An individual physician;
- o A Federally Qualified Health Center or other designated clinic; or
- o A participating Health Maintenance Organization in the Chicago area.

Physicians providing services under the managed care program will receive a patient management fee for each enrolled client.

As a result of extensive recruitment efforts, the Department has successfully enrolled providers with capacity exceeding the pregnant women and children expected to be enrolled in the program. However, recruitment efforts will continue in an effort to add additional quality providers to the program to enhance and increase the client choice process.

CONTACT: Dawn Claborn, Manager
Maternal and Child Health/Managed Care
Illinois Department of Public Aid
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, IL 62763-0001
(217) 524-7478

HMOs

Since 1974, the Department has contracted with HMOs to provide comprehensive prepaid care to AFDC-MAG recipients. The HMO Program was developed to:

- o alleviate the shortage of family practitioners serving Medicaid clients;
- o reduce client usage of emergency room for ambulatory services;
- o provide better access to preventive as well as episodic care; and
- o contain the rising cost of comprehensive care.

HMOs contract with employer groups, individuals and public health program agencies to provide care members through a large panel of providers, including managing members' health care through primary care physicians, arranging support services and specialist treatment, and processing all related claims.

The Department's HMO Program contains the following characteristics:

- o only AFDC-MAG recipients in Cook County have been eligible to date;
- o the Department will be accepting proposals for other service areas in FY 94;
- o voluntary and open member enrollment and disenrollment;
- o all Medicaid services except dental and optical are covered;
- o payment is made at the beginning of the month according to a capitation structure based on the age and sex of the recipient to remove the incentive for enrolling only low cost recipients, and to avoid paying the HMO any more than what the Department would pay in FFS costs;

- o the enrolling recipient selects a clinic site within the chosen HMO, and also selects a physician from whom he or she will receive most ambulatory care, including periodic checkups.
- o this physician orders all tests, makes all specialist referrals, and arranges hospital care if necessary;
- o requirements and features of the Health Moms/Healthy Kids Program are being added in 1993.

About 103,000 recipients are enrolled in Medicaid HMOs.

Monitoring. Federal Medicaid regulations require annual evaluation of HMO quality of care by an independent Peer Review Organization (PRO). The Department contracted Crescent Counties, a PRO, to perform such an evaluation even before this was a Federal requirement. However, as this only allows periodic monitoring on a limited scope, the Department views the PRO review as only a supplement to its own internal monitoring activities, which allow the agency to identify and respond to issues proactively on an ongoing basis, rather than depend on outside, annual reviews.

The Department's Prepaid Health auditors perform annual contract compliance audits of the HMOs to verify that Department contractual requirements, as well as State and Federal rules and regulations, are met. The Department's Health Facility Surveillance Nurses perform onsite inspections and chart reviews and attend HMO Quality Assurance Committee meetings to monitor the quality of care provided by HMOs, evaluate the HMOs' internal Quality Assurance programs, and recommend action to correct deficiencies. Utilization data submitted to the Department on a quarterly basis is profiled by provider, site, HMO, disease or procedure for use by the monitoring staff. Finally, the Prepaid Health Program staff monitors and investigates the field activities of HMO marketing representatives. All marketers are registered with the Prepaid Health Section, and violators are suspended from marketing to Medicaid recipients or appropriately reprimanded.

HMO financial stability is also reviewed annually by the Department's Internal Audits office, which contracts CPA firms to perform cost audits and report the net worth, assets and contingency reserves of each HMO.

Utilization data. The Department requires monthly submission of magnetic tapes containing records of all encounters and detailing recipient and provider identifiers, procedure codes, diagnosis codes and cost information. This data enhances the Department's capability to produce management reports on cost effectiveness as well as to assist the monitoring staff. Provisions exist to assess damages in the event of incomplete, inaccurate or tardy data. Data accuracy is verified against a sample of patient

charts in the contract compliance audits.

Finally, the Department is in the process of developing a multi-year managed care implementation plan with the objective of including as many Medicaid eligibles as possible throughout the State. A variety of approaches is being considered.

CONTACT: Dawn Claborn, Manager
Maternal and Child Health/Managed Care
Illinois Department of Public Aid
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, IL 62763-0001
(217) 524-7478

INDIANA

Current Coordinated Care Programs

HIO. Indiana has operated under a financing arrangement known as a HIO since March 1, 1986. This is a unique arrangement employed by only two State Medicaid Programs--Indiana and Texas. The HIO was originally selected by the Department of Public Welfare as both a means to contain costs and share the risk associated with the Medicaid Program. The HIO includes all aspects of administering a full-services insurance contract, including managing the investment banking functions related to the reserves. These functions are in addition to the typical functions of processing claims, handling eligibility and servicing health care providers included in most fiscal intermediary arrangements. The HIO is a method of financing Medicaid Program expenditures which places an emphasis on containing health care costs using financial incentives.

The HIO process works in the following fashion. Pure premium rates are established for each Medicaid recipient class based on historical benefit costs, anticipated health care trends and anticipated program changes. Pure premium payments are paid to the HIO contractor based on the number of recipients eligible for the program at the beginning of each month. In addition, the contractor receives an administrative fee to perform all of the services listed in the contract including prior authorization, third party liability, surveillance/utilization review, claims processing, nursing home inspections, and systems maintenance and development for the Indiana Management Information System (IMMIS).

Premium payments are deposited into a Medicaid Reserve account which is used for the payment of claim liabilities as they are presented for payment. Because of timing differences between the

date claims are incurred and when they are submitted or payment, the balance in the Medicaid Reserve grows. The fund is invested by the contractor and the State is paid interest on the account at a rate equal to the 26-week Treasury Bill rate. Any interest earned in excess of this rate is retained by the contractor as a fee for investing the funds. One year after the end of the fiscal year, a final accounting is conducted to compare claims paid to premium payments. If actual costs were less than premium payments, the contractor receives 15 percent of the difference and the State receives the other 85 percent. If claims costs were more than the premiums paid, the contractor deposits 15 percent of the losses into the Medicaid Reserve account. The State is responsible for depositing 85 percent of the loss. The contractor's gains and losses are capped at 10 percent of the annual premium paid.

Poverty level pregnant women and children claims, waived-services claims, targeted case management claims, and long term care claims, are "outside risk" and not subject to the quota share arrangement. However, these claims are processed for payment by the HIO contractor.

CONTACT: Pat Nolting
Office of Medicaid Policy and Planning
402 W. Washington St., Room W382
Indianapolis, IN 46204
(317) 232-4318

HMO. Indiana's Medicaid program has one HMO, Metrohealth, through Maxicare Indiana. MetroHealth is available only to the Marion County AFDC population, who may voluntarily enroll in the program. (Marion County includes the city of Indianapolis.) There is a continuous open enrollment period during which the provider enrolls Medicaid recipients eligible for coverage in the order in which the recipient makes application.

Sentinel, the contractor designated by HCFA to perform the annual external assessment for HMOs in Indiana, has reviewed MetroHealth in the past and did so again in 1991.

MetroHealth is paid at a monthly capitated rate. If a recipient incurs more than \$50,000 of medical expenses in an annual period beginning with November 1, MetroHealth can be reimbursed on a FFS basis for that recipient once these expenses have been documented. MetroHealth is required to provide all Medicaid

covered services to enrolled recipients and a Quality Assurance Program to provide a mechanism to assure that care and services provided to enrollees are consistent with community and national standards of practice.

CONTACT: Carol Gable
Department of Public Welfare
402 W. Washington St., Room W371
Indianapolis, IN 46204
(317) 232-2091

IOWA

Current Coordinated Care Programs

The State of Iowa Medicaid Program has two methods of providing coordinated or managed care to Medicaid recipients under Title XIX.

HMOs. The State has a contract with Heritage National Healthplan to provide HMO services to clients (AFDC and AFDC related groups) in the Davenport (Scott County) and Waterloo (Black Hawk County) service areas. This contract is for all services under the Medicaid plan, with the exception of dental, chiropractic, pharmacy services, durable medical equipment, inpatient mental health institute services, hospice services, special services for the chronically mentally ill, and nursing facility services. Services must be provided within the plan with the exception of emergency services and family planning.

Rates are based on actuarially sound principles developed under a contract with a firm selected from an RFP issued by the State. The rates are based on a percentage of the State FFS payments, established for specific groups of the Medicaid population (age, sex, etc.). Currently the HMO is receiving 94 percent of the FFS rate as its monthly capitated payment. The rate setting methodology is currently undergoing a review to ensure continuing compliance with upper limit guidelines. Clients may request disenrollment from the HMO at anytime, effective the end of the month.

Current enrollment in the HMO in Scott and Blackhawk Counties as of 7/15/93 is 12,967. This is a large increase from the number which were voluntarily enrolled in the HMO in Scott County only prior to a §1915(b) waiver for freedom of choice implemented in the State in July 1990.

The Medicaid Program is attempting to expand HMO coverage even further to other areas of the State. Heritage and seven other HMOs have certificates of authority for various locations within the State.

CONTACT: Ruth Schlesinger or Mary Roberts
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319
(515) 281-5755 or (515) 281-8747

Waiver Services. The State currently has a §1915(b) waiver which allows a restriction on freedom of choice to permit managed care by physician patient managers. There are currently 11 counties under the approved waiver, however, the program has not been implemented in four counties--Clinton (Clinton), Dubuque (Dubuque), Woodbury (Souix City), and Wappelo (Ottumwa)--because there was not sufficient physician participation to give access to medical care for the population. The State currently has 43,031 clients enrolled in the following counties: Jackson, Scott, Muscatine, Linn, Black Hawk, Polk, and Pottawattamie.

The State hired a contractor April 1, 1993 to assist with ongoing maintenance of the program and to expand the waiver program and the HMO program discussed above. The State has set a goal of enrolling an additional 58,000 AFDC and AFDC-related Medicaid recipients in managed health care by June 30, 1994. The State will utilize the waiver program as the basis for this expansion, but plans to expand the HMO program and implement other managed health care alternatives where feasible.

Clients are given a choice to enroll in either the Medipass program or a participating Medicaid HMO. Currently Blackhawk and Scott County have the HMO option. The client may choose the physician case manager of their choice as long as the physician has signed an agreement with the State to accept Medipass clients. Physician managers receive a \$2 a month payment for each patient on their list and in turn is expected to act as a "gatekeeper" to services for the patient. Physician managers must maintain 24 hour "access and availability", and must refer for necessary specialty services. The manager's role is to control the utilization of the recipient who might tend to overutilize services and to serve as an advocate for the recipient who might underutilize services.

The waiver was renewed effective July 1, 1992, for a two year period.

CONTACT: Nanette Foster Reilly or Mary Roberts
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319
(515) 281-6087 or (515) 281-8747

KANSAS

The Kansas Department of Social and Rehabilitation Services currently has one §1915(b) freedom of choice waiver in effect under the Medicaid program. The State has attempted in the past to enroll HMO providers without success.

Waiver Services. The Kansas Primary Care Network (PCN) was established in February 1984 as one of the first §1915(b) waivers to provide physician case management to clients in the urban area of Kansas. The project started with demonstrations in the counties of Sedgwick (Wichita), Saline (Salina) and Washington (Minneapolis). The State found early in the project that the rural counties did not show any cost effectiveness since the limited number of providers do not change the practice of referral. Therefore, Washington County was dropped from the project. At the time of renewal, the State added other urban areas to the waiver. These were Johnson, Wyandotte (Kansas City), Leavenworth, Douglas (Lawrence) and Shawnee (Topeka). The State has reviewed the waiver several times, and HCFA Regional Office reviews have shown the waiver to be effective in obtaining access to services for the Medicaid patient. The waiver has also proved cost effectiveness.

The populations covered under the waiver are AFDC, SSI and GA/MediKan eligible recipients. Approximately 60,000 recipients were enrolled in the program as of May 1993.

The client is allowed to select from the list of participating providers to be the physician case manager. The case manager is paid \$2 a month for each patient on his list. For this reimbursement, the physician must maintain access to service, and

the physician must refer for services that cannot be provided by the doctor. The concept is to reduce the overutilization of services by having one physician contact who manages all the care of the patient.

CONTACT: Dorothy Hunt
Department of Social and Rehabilitation Services
Medical Services
Docking State Office Building
Topeka, KS 66612
(913) 296-3981

KENTUCKY

The Kentucky Department for Medicaid Services implemented the Kentucky Patient Access and Care Program (KenPAC), a PCCM program, on February 1, 1986. Under the KenPAC Program, Medicaid families with children are provided a primary care (KenPAC) physician who has agreed to provide their primary medical care and will refer and authorize other specialty care services. Through a contractual arrangement with the Department, the KenPAC physician must be available 24 hours a day, seven days a week and provide total management of the KenPAC recipient's non-emergency medical needs.

Eligible KenPAC Medicaid recipients include AFDC and AFDC-related, children in intact families, and poverty level pregnant women and children.

The KenPAC program is mandatory for eligible recipients and is operated under the authority of the Secretary of Health and Human Services through a freedom of choice waiver. For their services, KenPAC physicians receive a \$3 per month per enrollee patient management fee in addition to the regular Medicaid FFS payments for any medical services provided to their enrollees.

Services which are managed by the KenPAC physician are:

- o physician services;
- o pharmacy services, when the prescription is issued by the primary physician or clinic;
- o hospital inpatient and outpatient services;
- o home health agency services;
- o laboratory services;
- o ambulatory surgical center services;
- o primary care center services;
- o rural health center services;
- o nurse practitioner services;
- o durable medical equipment and supplies;
- o nurse anesthetist services; and

- o durable medical equipment and supplies.

Excluded from management are any emergency medical needs.

In the above service elements KenPAC does not cover mental health/mental retardation services, psychiatric, ophthalmology, obstetrics, or routine newborn care billed under the mother's medical assistance identification number. Currently, 112 of Kentucky's 120 counties are covered by the KenPAC program, covering approximately 305,000 Medicaid recipients through contract with 1,098 physicians.

Highlights of the most recent independent evaluation include a high degree of satisfaction with the KenPAC Program by KenPAC recipients and physicians, KenPAC controls unnecessary referrals to medical specialists and inappropriate inpatient admissions, and estimated cost savings to the Medicaid Program of \$171 million over the first 60 months of operation.

CONTACT: Janie Miller, Acting Commissioner
Kentucky Department for Medicaid Services
Cabinet for Human Resources
Commonwealth of Kentucky
Frankfort, KY 40621-0001
(502) 564-4321
or
Larry McCarthy, Director
Division of Patient Access and Assessment
CHR Building
Third Floor East
275 East Main Street
Frankfort, KY 40621
(502) 564-5472

LOUISIANA

Current Coordinated Care Programs

CommunityCARE is a Primary Care Case Management (PCCM) managed care program administered by Medicaid of Louisiana. The program provides Medicaid recipients in designated parishes with a physician, Federally Qualified Health Center (FQHC) or rural health clinic as the recipient's primary care physician (PCP). Medicaid of Louisiana operates CommunityCARE under a waiver of freedom of choice under the authority of section 1915(b)(1) of the Social Security Act.

The goal of the program is to improve the accessibility, continuity, and quality of care to recipients, while reducing the overall cost of care by strengthening the patient/physician relationship and discouraging inappropriate or unnecessary

utilization of care. The Program is operational in six parishes and HCFA approval has been requested for additional parishes.

For their services, CommunityCARE providers receive a \$5.00 per month per enrollee patient management fee in addition to the regular Medicaid fee for service payment. In addition to meeting Medicaid enrollment criteria, participating PCPs must have hospital admission privileges, give written referrals, provide 24 hour access and provide or arrange for EPSDT services.

As the care manager, the PCP bears total responsibility for managing all facets of the recipient's health care. This responsibility includes providing patient education, preventive care, maintenance and acute care, and referral to specialists when necessary. The population includes AFDC and SSI recipients.

CONTACT: Sondra K. Burns
Bureau of Health Services Financing
CommunityCARE Program
P.O. Box 91030
Baton Rouge, LA 70821-9030
(504) 342-1304

MAINE

The Maine Bureau of Medical Services will be submitting a 1915(b) waiver to HCFA in August, 1993 for the implementation of a Statewide primary care case management system. This managed care system will require mandatory participation on the part of AFDC and AFDC-related eligibles. Participating primary care providers will receive a \$3.00 per enrollee per month fee for the management of their panel of patients in addition to the fee-for-service reimbursement for medical services. Implementation on a site by site basis is scheduled to begin in late 1993. When fully operational, approximately 100,000 Medicaid recipients will be participating.

Maine is also developing several risk-based contracting arrangements for Medicaid managed care. It is anticipated that contracts will be negotiated for both fully capitated and partially capitated programs. Enrollment by Medicaid recipients will be voluntary, but they will be required to enroll in the PCCM system if they do not choose the capitated model. Implementation of these risk-based contracts is slated for 1994.

CONTACT: Elizabeth McCullum, Director
Bureau of Medical Services
Department of Human Services
State House - Station #11
Augusta, ME 04333
(207) 287-2674

or

Deborah Curtis, Director
Division of Managed Care
Bureau of Medical Services
State House Station #11
Augusta, ME 04333
(207) 287-3835

MARYLAND

Maryland Access to Care Programs (MAC). The Maryland Access to Care (MAC) Program links Medical Assistance recipients with primary medical providers (PMPs) who provide primary health care and serve as gatekeepers for the provision of specialty care. The PMPs include physicians engaged in family practice, general practice, pediatrics, and internal medicine, as well as nurse practitioners. Under certain circumstances, another type of specialty physician may be designated as a MAC PMP when it is in the best interest of, and requested by, the recipient. PMPs must have regular office hours, 24 hour call and coverage arrangements, and participate in the EPSDT Program if they serve children. By stressing access to primary care, MAC seeks to promote quality, continuous care and provide recipients with a "medical home." Unlike other States with similar programs, Maryland does not pay a monthly per person management fee. Instead, concurrent with the start of the MAC Program, office visit fees for primary care were raised by an average of 50%. The decision to raise fees rather than have a monthly per person payment was made after consulting with the leadership of the Maryland physician community.

The MAC Program began December 9, 1991, and has enrolled approximately 225,000 recipients. MAC is operational under a HCFA waiver and applies Statewide to designated categories of recipients. The MAC Program applies to most Medicaid recipients with two major exclusions: 1) Recipients enrolled in a Medicaid HMO; and 2) Recipients for whom the State pays Medicare premiums. There are additional exclusions for those enrolled in other Medicaid managed care programs, those in State institutions and foster care, and subsidized adoption cases. A complete evaluation of the Program is being conducted by Project Hope under a grant from the Health Care Financing Administration and should be completed this year.

CONTACT: Dawn L. Grosshandler, Assistant Director
for Maryland Access to Care
Medical Care Operations Administration
Department of Health and Mental Hygiene
201 West Preston Street, Room L-9
Baltimore, MD 21201
(410) 225-5444

HMOs. The State of Maryland has offered HMO services to recipients since 1975. There are currently five HMOs on contract which serve recipients in Baltimore City and surrounding metropolitan counties. The State's most recent contract will open the service area to Statewide participation in 1994. There were 69,347 Medicaid recipients enrolled ending fiscal year 1993, with program expenditures of \$131,400,733.

All Maryland Medicaid Programs are regulated by the Department of Health and Mental Hygiene. All HMOs participating in the Medicaid Program must also operate under the regulations established by the Maryland Insurance Commissioner.

ENROLLMENT

Enrollment in HMOs is voluntary. Providers are responsible for direct marketing with the State providing assistance in the form of mailing and other administrative services. The Department also provides an "HMO Hotline" for MA recipient which functions as a patient advocate.

CAPITATION RATES

Rate setting methodology was developed by independent financial consultants and based on sound actuarial principles. Nineteen different rate categories are developed from fee-for-service equivalents based on eligibility, age and sex. Contracts are negotiated and are currently paid at 95.5% of fee-for-service, including a consideration for administration. There are several risk options developed by the Department, consisting of catastrophic limits for combined inpatient hospitalization and psychiatric day care.

COMPLIANCE

The program carries out quality assurance activities through annual chart audits conducted by an independent contracted Peer Review Organization. Additionally, the Department performs its own chart audits to assure the HMOs compliance with the EPSDT programs. Disenrollments and patient advocacy issues are monitored through the Department's "Hotline."

HMOs are required to directly provide or arrange for all medically necessary services available to fee-for-service recipients under the State plan with the exception of long term institutional nursing care.

CONTACT: Katherine C. Tvaronas
Staff Specialist for the HMO Program
Division of Primary Care
Medical Care Policy Administration
Department of Health and Mental Hygiene
O'Connor Building, Room 120
201 West Preston Street
Baltimore, MD 21201
(410) 225-1482

Corrective Managed Care Program. The Corrective Managed Care Program has been in existence since 1984. The purpose of the program is to promote coordination and continuity of health care, to assist recipients to use the health care system appropriately and effectively, and to reduce program costs. Enrollment in Corrective Managed Care has as its basis the identification of recipients with behavioral patterns indicative of potential misutilization. A computer program with constantly refined exception parameters produces reports used to identify recipients whose payment histories suggest possible misuse of benefits. A detailed payment history is reviewed on each of these recipients by trained medical professionals to determine if a pattern of misuse actually exists, with the health care providers who delivered the services contacted wherever necessary. A recipient determined to have misused benefits will be enrolled with a managed care provider and a designated pharmacy for a period of two years. During the two years, the recipient must secure all health services not otherwise exempted by regulation directly, or by referral, from the Corrective Managed Care provider and must obtain prescriptions from only the designated pharmacy.

Primary care physicians and community health centers are enrolled as Corrective Managed Care providers upon agreeing to participate in the coordination of health care for assigned recipients. Each provider must meet specific conditions of participation including 24 hour/seven day a week coverage and a minimum number of scheduled office hours. In addition to any customary FFS furnished to the Corrective Managed Care Provider for services to an enrolled recipient, the provider is also paid a retainer fee of \$5 per month per assigned recipient irrespective of whether the recipient utilizes services that month. In

July 1991, over 700 managed care providers participated in the program and over 2,900 recipients are enrolled statewide. The elimination of the State-only program after December 1, 1992, reduced CMC enrollments to approximately 1300 current recipients.

CONTACT: Sharon Libershal, Chief
Managed Care Section
Division of Utilization and Eligibility Review
Medical Care Compliance Administration
Department of Health and Mental Hygiene
2nd Floor - O'Connor Building
201 West Preston Street
Baltimore, MD 21201
(410) 225-1678

Diabetes Care Program (DCP). DCP is available to a recipient who has diabetes, has been discharged from a hospital inpatient stay for a diabetes-related diagnosis, and meets other specific requirements (e.g., is not a Medicare beneficiary, a nursing facility patient, or HMO enrollee.) Enrollment is voluntary, but once enrolled in DCP the recipient must obtain health care from a single diabetes primary care provider (PMP) or upon referral from that provider to other providers. Unlike the Corrective Managed Care program described above, an enrollee is not restricted to a single pharmacy. The program is designed to operate statewide under a HCFA waiver and was implemented on June 1, 1991. Two thousand recipients are enrolled in the Program currently.

Enrollees may receive additional services which are not available to non-enrollees. These services include diabetes outpatient education, nutritional counseling, and therapeutic footwear, as well as items of disposable medical supplies and durable medical equipment usually available only to insulin-dependent diabetic recipients. Recipients enter the program by signing a voluntary enrollment form which may be obtained from the Program or from hospital discharge staff. Hospitals are required to notify the DCP of every recipient who is discharged after inpatient treatment of a diabetes-related condition. Recipients are enrolled for an indefinite period of time but may change their primary medical provider or terminate their participation at any time.

A diabetes primary medical provider (PMP) must meet special requirements in addition to meeting the basic Maryland Medicaid qualifications as a physician services provider in a private or group practice, a nurse practitioner, or a free-standing clinic. PMP physicians and nurse practitioners are required to take a continuing medical education course on diabetes management within 12 months of beginning to provide services to recipients. Each primary medical provider must sign an agreement to provide coordination of health care for assigned recipients and to maintain a minimum number of scheduled office hours and 24

hour/seven day a week coverage. A monthly managed care fee of \$20 per enrollee is paid to the PMP irrespective of service delivery during the month. Diabetes nutrition counseling must be rendered to program participants by licensed nutritionists or dietitians, and diabetes outpatient education must be furnished by a provider certified by the Office of Chronic Disease Prevention of the Maryland Department of Health and Mental Hygiene.

CONTACT: Nanette Rosendale, Program Coordinator
Diabetes Care Unit
Division of Utilization and Eligibility Review
Medical Care Compliance Administration
Department of Health and Mental Hygiene
2nd Floor - O'Connor Building
201 West Preston Street
Baltimore, MD 21201
(301) 225-1678

MASSACHUSETTS

The Massachusetts Division of Medical Assistance is in its second year of implementing Mass Health Managed Care, a comprehensive program that affects over 460,000 recipients. The program has four principal components: the Primary Care Clinician Program, Mental Health and Substance Abuse Program, the HMO Program, and the Health Benefits Manager Program. In Managed Care, recipients choose either an HMO or a Primary Care Clinician (PCC).

Primary Care Clinician Program

The Primary Care Clinician (PCC) Program is a form of primary care case management in which PCCs provide primary and preventive care and authorize most other medical services for patients enrolled with them. Over 3000 physicians are now enrolled in the program. They represent capacity to serve twice the State's number of Medicaid recipients. As of July 1993, the total number of recipients enrolled with PCCs was 217,000.

The goals of the PCC program are:

- o To increase access to and availability of preventive and primary care;
- o To improve quality, continuity and appropriateness of care; and
- o To improve program cost-effectiveness.

The evaluation tools the Division will utilize to measure the quality of the program include patient and PCC satisfaction surveys, service utilization reports, and clinical quality measures which highlight key program objectives and identify opportunities for improvement. Areas the Division will be

analyzing include asthma treatment, preventive care for children, and use of hospital emergency rooms.

The PCC agreement is not a risk-based contract. It does have financial and administrative incentives for participating providers. PCCs receive an additional reimbursement of \$10 per enrollee visit for primary and preventive care. PCCs are given the option of improving their cash flow by electing to receive a monthly prospective interim payment as an advance on actual claims. A dedicated toll-free telephone number offers easily accessible assistance for PCCs with billing or other questions.

Network management and development of risk-based reimbursement will be areas of special emphasis over the next year.

Mental Health/Substance Abuse Program

The Mental Health/Substance Abuse (MH/SA) Program seeks to ensure recipient access to medically necessary services in the most clinically appropriate, cost-effective settings. In its evaluation of the program, the Division will focus on the efficacy of treatment, in terms of recipient satisfaction, functioning and well-being. The Division has contracted with Mental Health Management of America, Inc. (MHMA) for implementation of the MH/SA Program.

Recipients participating in the MassHealth Managed Care initiative will receive their (MH/SA) benefits in one of two ways. Those in an HMO will receive MH/SA benefits through that HMO. Recipients choosing the PCC Program, and those who have not yet been enrolled with a medical provider, receive their benefits through MHMA. MHMA services can be obtained without a PCC referral.

Implementation of the MH/SA Program is being phased in over 1992. MHMA began service authorization and utilization review activities in April 1992 for in-patient services. Authorization and review for all outpatient services began on July 1, 1992. MHMA also became the claims processing/paying agent for all Division-certified providers of MH/SA services on that date. Additionally, during July MHMA began procuring diversionary services that were formerly non-reimbursable by Medicaid. In October 1992, MHMA put in place an acute inpatient service network through selective contracting. MHMA's selective contracting for outpatient services began in January 1993.

Early in 1993, the Division and MHMA developed and communicated policies for the exchange of information between MH/SA providers and PCCs. Over the next year, there will be qualitative analysis of such information sharing with special attention to measuring the frequency of informed recipient consent. As of June 1993, 374,000 recipients were enrolled with MHMA.

HMO Program

On January 1, 1992, the Division implemented an enhanced HMO program. The Division initiated a competitive procurement process through which fourteen qualified HMO vendors (now twelve due to mergers) were selected. An additional HMO will be added to the program in 1993. Two other capitation agreements are in place to provide benefits to special recipient populations: disabled person and individuals with AIDS.

The objectives of the HMO program are: 1. to coordinate efforts with the Health Benefits Management (HBM) Program (see below) to educate and assist recipients in their enrollment decisions; 2. to provide recipients with a variety of health plan and provider choices which satisfy the recipients' needs, as they define them; 3. to work with contracted vendors to ensure that they meet Division purchasing specifications and are continuously progressing in their efforts to improve or maintain recipient health status and the quality of services provided to recipients; and, 4. to constrain growth in per capita expense.

The HMO program has a number of new features including: an expanded benefit package for mental health, substance abuse, and early intervention services; access for disabled individuals; focus on quality services, including aggressive performance standards and quality improvement goals which are negotiated with each HMO and carefully monitored; and the transfer of marketing and enrollment functions from the HMOs to the Division's HBM Program.

Enrollment in the HMO program is voluntary and recipients may chose to transfer enrollment to a different HMO or to a PCC at any time. As of July 1, 1993, HMO enrollment was 92,000 - an increase of 37,000 enrollees in eighteen months.

Health Benefits Management Program

The objective of the Health Benefits Management (HBM) Program is to meet the health care needs of recipients, as they define them, by educating them about and assisting them in their selection of a health care provider from a range of Managed Care options. To accomplish this, the Division has contracted with Foundation Health Federal Services, Inc. Foundation has placed trained HBMs in every Welfare Office and staffs a central site accessible via a toll-free number.

After conducting a health assessment with a recipient, either in person or over the telephone, an HBM then provides the recipient with information about the HMOs and PCCs serving the recipient's area. Locations, hours, special services, language capability and other information is made available. The recipient's

questions are answered and she/he is encouraged to make a choice. Recipients who do not chose an HMO or a PCC within 30 days are assigned to a PCC. Assignment protocols take into account claims history, geography, language capabilities and age of recipient.

All eligible new cases since April 1992 have gone through the HBM process. In May 1992, the conversion of ongoing cases began. By June 1993, two-thirds of ongoing cases had been converted. The conversion of recipients in the disability aid categories will take place over the summer of 1993. Special outreach efforts are planned to reach these recipients. Conversion will be completed by the end of 1993.

CONTACT: Michael Bailit
Director of Managed Care Programs
Massachusetts Division of Medical Assistance
600 Washington Street
Boston, MA 02111
(617) 348-5510

MICHIGAN

Current Coordinated Care Programs

HMOs. The Medical Services Administration (MSA) of the Michigan Department of Social Services (MDSS) has contracted with HMOs to provide Medicaid (MA) covered health services since 1972. From the beginning, this program has been a successful means of containing Medicaid expenditures. Through 1986, the State has realized an estimated cost savings of \$48,000,000 representing the difference in Medicaid expenditures for HMO enrollees compared to expenditures for FFS recipients. Estimated savings for 1988 are \$10,000,000; for 1989 \$12,600,000. MDSS contracts with six State licensed, Federally qualified HMOs in nine Michigan counties with a current MA enrollment of 117,000 Medicaid recipients.

Contracting. MDSS actively seeks contracts with licensed HMOs in Michigan. Dialogues are initiated by MDSS and the HMOs; contract terms and capitation rates are shared.

MSA provides the HMOs with utilization and expenditure data. This enables the HMOs to compare service activity and costs of their enrollees with the Medicaid FFS market upon which the HMO payment rates are based.

Every other year MSA conducts onsite inspections for contract compliance. The HMOs are required to submit various articles for review (e.g., current approved Medicaid marketing material, updated listings of subcontractors.) While onsite, MSA staff review the claims processing system, insurance policies, random samples of grievances filed and other pertinent items as needed.

Upon completion of the onsite inspections the HMO receives a report of the findings.

From 1972 through 1979, HMOs were contracted on a cost basis since Federal regulations required that HMOs must be Federally qualified to be reimbursed under a risk contract. The cost settlement process was extremely cumbersome and continued well beyond the contract period involved. By 1980, contracts were on a risk basis.

Contracts are designed as a yearly document. Yearly changes are made as mandated by Federal and State laws; capitation rates are also updated each year. The contracts are standard and cover a calendar year.

Marketing. Marketing the HMO option to Medicaid recipients has been one of the most difficult problems. Initially, marketing was largely left to the contracted HMO. MDSS assisted only to the extent of providing names and addresses of Medicaid recipients within the area serviced by the HMO. HMO staff used a door-to-door approach in contacting these recipients. This approach was successful in enrolling a significant number of Medicaid recipients. However, it was discontinued when the Michigan Attorney General ruled that releasing recipient names and addresses breached confidentiality.

Through 1978 and 1979 several different marketing approaches were used. HMOs would market door-to-door in areas known to have a high concentration of Medicaid recipients. Efforts were made to enroll Medicaid recipients who were seen in an HMO clinic on a FFS basis. Also, former enrollees who had become ineligible for Medicaid were periodically recontacted to determine if they had regained eligibility.

Lately, MDSS has taken a more active role in marketing the HMO option. A brochure comparing HMO membership to FFS Medicaid was developed. This was provided to recipients at the time Medicaid eligibility was redetermined. A release form could be signed by the grantee to request additional information. The signature allowed MDSS to release the grantee's name, address and phone number to area HMOs for the purpose of providing this additional information. This "dual choice" project, however, did not prove to be successful in enrolling a significant number of recipients and has been discontinued.

Another pilot effort involved direct solicitation of Medicaid recipients at two MDSS local offices by an HMO/MDSS team. This effort also failed to result in significant numbers of new enrollees.

Mass mailings (at the HMO's expense) to Medicaid recipients for specific HMOs is an approach used recently. In this approach,

the HMO provides MDSS with marketing materials to mail to eligible Medicaid recipients in a specified area. Interested recipients may then contact the HMO for future information.

Enrollment. Most Medicaid recipients who live in an HMO service area have the option to voluntarily enroll in an HMO. However, a recipient cannot be enrolled in an HMO when the recipient is:

- o confined to an institutional setting (e.g., long term care facility or hospital);
- o active in the Crippled Children Program;
- o enrolled in another HMO; or
- o an active General Assistance client.

Michigan operated under a Federal waiver of §1903(m) permitting a lock-in for six months until December 31, 1983. As of January 1, 1984, HMO enrollees could elect to disenroll at any time.

The lock-in was reinstated effective July 1, 1987. This lock-in has two open window periods (May and November) for disenrollment. If a recipient chooses not to disenroll during these time periods then he/she must wait until the next open window period to disenroll.

Services. The HMO must provide at a minimum the Medicaid covered services listed in the Medical Assistance Program Manuals. The HMO either directly renders or authorizes all contracted medical services. If the Medicaid recipient requires non-covered services (e.g., long term care), he/she is disenrolled from the HMO and receives the service in the FFS environment. The recipient can receive dental services from a FFS provider and remain an HMO member.

Services Covered by HMOs

Ambulance
Family Planning
Hearing Aid Dealers
Home Health
Hospital
Laboratory
Medical Supplies
Methadone Maintenance
Pharmacy
Physician (including Chiropractor
and Podiatric)
Vision

Services Not Covered by HMOs

Hospice
Long Term Care
Dental Services

Rate Setting. The MDSS capitation rates are based on the FFS costs of a like population for covered services for the contractor's service area. The MDSS rate-setting system provides

recipient-based cost and eligibility data specific to county, program of assistance, age, and sex. The initial data base in capitation rate calculation is the most recent calendar year (date of service) cost and eligibility data. Any adjustments to the program effective with the new fiscal year will be reflected in the new contract year. Other adjustments to the rate-setting system consist of: gross adjustments, undifferentiated charges, administrative expenses, and copayments. Income investment and incurring factors are also included as adjustments to the data base. The final projected total is then dispersed into the age/sex/program rate categories, and the estimated average per capita cost is calculated by the MDSS. This reimbursement is from 90 percent to 98 percent of FFS based on a comparison of the FFS costs in the rate-setting region to the highest rate-setting region.

Reimbursement. The individual enrollee capitation is paid through the Medicaid invoice processing system via submission and processing of paper invoices or magnetic tape for individual enrollees each month. The program's Remittance Advice serves as a vehicle for payment and documentation of eligible enrollees.

Prior to February 1983, invoices were processed in the month prior to the month for which capitation was being paid. This prepayment resulted in reimbursement for enrollees subsequently determined ineligible. In February 1983, payments were changed to the month of capitation.

While the Remittance Advice still serves as the payment vehicle, a listing of HMO eligible enrollees had to be created. It is produced and mailed to the HMOs before the first of each month. Effective June 1, 1986, MSA agreed to force payment for all enrollees whose names appear on this list. Certain exceptions were made, i.e., admission to a LTC facility or State institution, eligibility for crippled children or General Assistance, death, or moving out of the service area.

Role of Other State Agencies. Under State law in Michigan, two State agencies have responsibility for HMOs, the Department of Public Health (MDPH) and the Insurance Bureau of the Department of Licensing and Regulation.

The MDPH is primarily responsible for monitoring the health care delivery system of HMOs. Such activities encompass medical record requirements, quality assurance programs, physical plant, provider staffing, delivery system (including required services and subcontracts for all referral services), service area, utilization reporting, and enrollment activity. The MDPH conducts periodic onsite inspections of medical records, physical plant, peer review activity, and quality assurance programs. MHOs are required to submit quarterly and annual reports to the MDPH providing aggregate utilization data and enrollment data.

Further, the MDPH informs the MSA of HMO related matters. This encompasses notification of applications for intent and licensure, service area expansion, and physical plant expansion. Copies of aggregate utilization reporting and enrollment data are provided as well as copies of medical record reviews and quality assurance program reviews and, when necessary, deficiency reports, corrective action requirements, and follow-up reviews.

The Insurance Bureau is primarily responsible for monitoring the financial condition of HMOs. The Insurance Bureau must approve all private market premiums (capitation rates) and is responsible for monitoring marketing practices and grievance programs and procedures. Further, the Insurance Bureau is responsible for monitoring reinsurance programs as well as general liability insurance, worker's compensation, and employee benefits programs. HMOs are required to file an annual report of grievance statistics as part of the annual financial report. The Insurance Bureau conducts periodic audits.

CONTACT: Judith A. Wilson, Manager
Managed Care Section
Medical Services Administration
400 South Pine Street
Lansing, MI 48909
(517) 335-5528

Medical Assistance/Clinic Plan Program. MSA implemented the Capitated Clinic Plans (CPs) in April of 1983 on a pilot basis. The clinic plan program operates under waivers of specific Federal regulations per requirements of §§1915(b), 1902(a)(1), 1902(a)(10), 1902(a)(23) and 1902(a)(30) of the Social Security Act.

On two separate occasions MSA solicited applications, once in 1982 and then again in 1986. An interdepartmental review committee reviewed the applications for various information and documentation, for example: prior experience in ambulatory health care, referral network, documentation of financial viability, etc. Those that met the criteria were accepted.

The program permits Medicaid recipients to select and enroll voluntarily in participating clinics and physician group practices to receive all their ambulatory and physician care. This program has been a successful means of containing Medicaid expenditures. The State has realized a 12 percent cost savings in Medicaid expenditures for CP enrollees compared to FFS recipients. MDSS contracts with five CPs in four Michigan counties with a current MA enrollment of 8,605 recipients.

Program Structure. A Clinic Plan is a program of partial capitation. Most ambulatory services are reimbursed through

capitation while payments of inpatient hospital facility charges are the responsibility of the State. CPs authorize inpatient hospital admissions and services and share in any savings accrued as a result of the program. An incentive/bonus payment is paid the contractor if costs are less than 80 percent of what was expected if the recipient had been in FFS. The contractor's bonus is equal to 50 percent of the difference between actual cost and 80 percent of expected cost. (There is no penalty if the CP inpatient costs are higher.)

Contracting. MDSS contracts with CPs in Michigan on a periodic basis. Dialogues are initiated by MDSS and the CPs; contract terms and capitation rates are shared.

Contracts are designed as a yearly document. Yearly changes are made as mandated by Federal and State laws; capitation rates are also updated each year. The contracts are standard and cover a calendar year.

Marketing. Marketing is primarily the responsibility of the CP. MDSS is responsible for determining the Medicaid eligibility of each enrollee and for notifying the CP of any changes in an enrollee's eligibility.

Each CP must conduct its marketing so that recipients are provided with adequate information to make an informed choice. The CP must assure that each recipient understands how to use the plan, including the restrictions on out-of-plan use. All marketing materials and procedures must be submitted to MDSS for approval prior to use.

The CP may offer additional services to the recipients as an incentive to enroll in the plan.

Enrollment. Most Medicaid recipients who live in a CP service area have the option to voluntarily enroll in the CP. However, a recipient cannot be enrolled in a CP when the recipient is:

- o confined to an institutional setting (e.g., long term care facility or hospital);
- o active in the Crippled Children Program;
- o enrolled in another managed care program; or
- o an active General Assistance client.

Services. The CP must provide at a minimum the Medicaid covered services listed in the Medical Assistance Program Manuals. The CP either directly renders or authorizes all contracted medical services. If the Medicaid recipient requires non-covered services (e.g. long term care), he/she is disenrolled from the CP and receives the services in the FFS environment. The recipient can receive dental and inpatient hospital services from a FFS provider and remain a CP member.

Services Covered by CPs

Ambulance
Family Planning
Hearing Aids
Hearing and Speech
Home Health
Hospital (Outpatient) including
 emergency room
Laboratory
Medical Supplies
Methadone Maintenance
Pharmacy
Physician
Vision

Services Not Covered by CPs

Hospice
 Long Term Care
Dental
Inpatient Hospital
 Community Mental Health
 Services

Rate Setting. The MDSS capitation rates are based on the FFS costs and eligible months of a like population receiving covered services in the contractor's rate setting area. The MDSS rate-setting system provides recipient-based cost and eligibility data specific to county, program of assistance, age, and sex. The initial base in capitation rate calculation is the most recent complete calendar year (date of service) cost and eligibility data. All program changes impacting CPs are incorporated into the rates. Other adjustments to the rate-setting system consist of gross adjustments, undifferentiated charges, administrative expenses, and copayments. Income investment and incurring factors are also included as adjustments to the data base. The final projected cost total is then dispersed into the age/sex/program rate cells, and the estimated average per capita cost is calculated by the MDSS. This reimbursement is 100 percent of FFS reimbursement. Inpatient target rates are set using the same methodology. Inpatient target rates are at 80 percent of FFS capitation rates and are also based on age/sex/program cells.

Reimbursement. The individual enrollee capitation is paid through the Medicaid Invoice Processing system via submission and processing of paper invoices or magnetic tape for individual enrollees each month. The program's Remittance Advice serves as a vehicle for payment and indicates resolution of each claim.

While the Remittance Advice serves as the payment vehicle, a listing of eligible CP enrollees is sent to the CPs each month. It is produced prior to the first of the month and lists all enrollees having eligibility for the subsequent (report) month. Enrollees whose cases are in negative action (in review) at the time the report is produced do not appear on the report. Because case action is taken on an ongoing basis the reports are not totally accurate on the first of the report month. Effective June 1, 1986, MSA agreed to force payment for all ineligible enrollees whose names appear on this list. Certain payments

exceptions were made, i.e., admission to LTC facility or State institution, eligibility for Crippled Children or General Assistance, death, or moving out of service area.

CONTACT: Judith A. Wilson, Manager
Managed Care Section
Medical Services Administration
400 South Pine St.
Lansing, MI 48933
(517) 335-5528

Medicaid/Physician Sponsor Plan (PSP) Program. PSP was implemented July 1, 1982, in Wayne County, Michigan. The plan was devised by the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons in response to a legislative request for a proposal outlining an alternative reimbursement approach. The costs of Medicaid were rising at a rate exceeding that of inflation. Physicians were paid on a FFS basis. Clients received a Medicaid card which could be used to access Medicaid covered services with very few limitations (e.g., nominal copayments on some services and prior authorization needed on certain services such as dental and durable medical equipment.)

The Plan. The PSP proposal submitted by the medical societies retained FFS reimbursement but differed significantly from the existing delivery system. Under the PSP, each client selects a primary care physician who becomes the client's physician sponsor. The sponsor either directly renders or authorizes most medical services. Some services do not require an authorization. These are: emergency services, chiropractic, podiatric, hearing, clinic, nurse midwife and dental. Radiology, pathology and pharmacy services do not require direct authorization but must be ordered by a physician and the physician must have an authorization. The sponsor receives a case management fee of \$3 per month per enrolled recipient (to a maximum of \$3,000 per month.) This fee is to offset the cost of maintaining a 24 hour access system, reviewing periodic utilization reports and establishing a referral mechanism. Continuation of the fee is contingent upon program savings. The selected sponsor's name will appear on the client's Medicaid card and remain there until either the sponsor or the recipient requests a change.

The Contract. All doctors in and around the Wayne County demonstration area were sent an application. Any doctor can be a sponsor but the doctor must have a primary care mode of practice or agree to render primary care to his/her enrollees. The contract is a one year, renewable document. It outlines the responsibilities of both the physician sponsor and the department. It also details contract sanctions.

Contract compliance is monitored in two ways. First, enrolled

recipients and medical providers call in complaints. All complaints are investigated and may lead to contract sanction or termination. Second, an analyst does onsite reviews using protocols developed for PSP contract compliance. The visit is also used as a tool to educate physician sponsors about the concept of managed care.

Enrollment. Enrollment is mandated for all AFDC and AFDC-related Medicaid eligibles in Wayne County with the following exceptions:

- o long term care patients;
- o recipients active in the Crippled Children Program or in foster care;
- o recipients already enrolled in a medical care management program (HMO or Clinic Plan); or
- o recipients in the Recipient Monitoring Program.

Recipients may change sponsors upon request. Except in unusual circumstances, the change will take from two to six weeks to effect. Recipients may request an enrollment exception.

Marketing. The recipient marketing process has gone through several stages. Several methods have been found effective. Clients may enroll through their doctor's office. The sponsor has enrollment forms designed by the DSS and provided to the sponsor. AFDC clients must complete a form at eligibility determination and at redetermination. Periodic mailings include an enrollment form/mailer. Clients who do not respond to the mailer are assigned.

The PSP has staff available to assist in the enrollment process and to intervene if problems arise. Phone access is available 8.5 hours per day.

Requests for Proposal for the Managed Care Entry Plan (MCEP) have been mailed out to all participating HMOs, PSP doctors and Clinic Plans to submit proposals to become an entry plan provider. The MCEP providers will be assigned those recipients who fail to designate a choice within the prescribed time period. The providers are bidding on a geographic area; the price is not an issue. A maximum of 27 MCEP providers will be chosen. Once enrolled with the MCEP provider, the recipient continues to have the right to request a change or an exception. However, the MCEP enrollment will remain until the recipient takes a positive action.

Monitoring. To assess the impact of the PSP upon recipients, the DSS has contracted with an independent agency to monitor the implementation and the effect upon client access to care. Peat Marwick, the most recent contractor, would regularly survey recipients six weeks after enrollment and again six months after

enrollment to ascertain the recipient's experience under the plan. The contractor also monitors the sponsor's 24 hour availability. Problems encountered are reported to a Monitoring Committee and recommendations for resolution are given to the department. Individual problems are referred to the Sponsor Specialist Office for resolution. The Monitoring Contract is currently in the bid process.

Education. The PSP represents a shift in the way recipients receive care and also in the way physicians provide care. For this reason, educational information is supplied on a regular basis. Clients receive written booklets describing their options and how to use the system. A Tele-Med tape and video are also available.

Physicians receive program bulletins. There is also a provider Tele-Med tape. The Sponsor News is a publication produced periodically to provide educational material in an informal, interesting format.

Evaluation. The PSP was initially evaluated under a three year HCFA grant. For 1983 and 1984, the study compared like populations of enrolled and non-enrolled recipients. Cost effective care was evident for enrolled recipients. A net savings of \$108 per person per year was experienced. The savings were driven by AFDC clients aged 15 and above. There was a cost increase for AFDC children aged 14 and below. There was no significant change for SSI clients.

A second evaluation for 1986 used a different design approach. A per person rate was established for enrolled and unenrolled recipients within the county using HMO rate setting age/sex/program cells. Considerable (12 percent) cost savings were apparent but the study design was flawed because other variables, e.g., adverse selection, were not controlled. The study results confirmed cost effectiveness but the next evaluation design will address questions left unanswered with this study.

A third evaluation looking at the 1988 and 1989 experience is now underway.

Legal Base. The PSP is operating under waivers of the Social Security Act. Waiver of §1902(a)(1), (7), (10) and (23) were authorized under the authority of §1915(b)(1) of the Act. The

Michigan appropriations bill annually directs the DSS to continue implementation of the plan.

CONTACT: Judith A. Wilson, Manager
Managed Care Section
Medical Services Administration
P.O. Box 30037
Lansing, MI 48909
(517) 335-5537

MINNESOTA

Prepaid, Capitated Programs

The Minnesota Prepaid Medical Assistance Program (PMAP) provides managed health care under the original mandatory demonstration design in three counties: Hennepin, Dakota, and Itasca. Expansion to Ramsey County began in March of 1993. Enrollment in this county will be complete in June of 1994. Hennepin, Dakota and Ramsey Medicaid (MA) recipients have a choice of health plans. These plans contract with the State to provide all MA services in exchange for a capitated payment rate that is based on the State's experience in providing fee-for-service (FFS) coverage. In Itasca County, the program is somewhat different. The county acts as the health plan and is responsible for managing health care services provided to the county's MA recipients.

All PMAP enrollees are locked into the program for a period of one year. However, they are permitted to change health plans once during the initial year of enrollment. In Itasca County, they are permitted to change the primary care provider once during the initial year of enrollment. In addition, enrollees have the opportunity to change health plans during the open enrollment period in November of each year. Generally, fewer than 4% change plans during open enrollment.

Minnesota has a similar managed care program for its General Assistance Medical Care (GAMC) program in Hennepin, Dakota, Itasca, Ramsey and Lake counties. In addition to the mandatory programs, a voluntary HMO program is offered. MA recipients who live in the metropolitan area, but not in managed care counties, can choose to enroll in health plans in order to receive their MA benefits.

Additionally, Minnesota elders can enroll in the Social HMO demonstration project which is a product of Group Health, Inc. and is called Seniors Plus. Seniors Plus provides for acute and long term care services for enrolled seniors.

Minnesota managed health care programs provide services to the

AFDC pregnant women, needy children, and elderly populations in the State. At present, Minnesota does not provide health care to disabled individuals under age 65 through managed care contracts. Additionally, there are certain groups excluded from PMAP, including foster children, new immigrants, and other groups for whom it would be difficult to provide care in managed care setting.

In 1994 and 1995, managed care will be expanded to ten additional counties. In addition, Minnesota has a Robert Wood Johnson Foundation grant to develop an integrated service system for seniors. This project is referred to as the Long Term Care Options Project. A managed care model for persons with physical disabilities or chronic illnesses is also under consideration.

In terms of external reviews, Minnesota complies with the provisions of OBRA '86 which requires review of States' managed care plans by independent accreditation organizations. This year HealthPro, Inc., of Worcester, Massachusetts is conducting the quality assurance audit. Finally, Minnesota is one of three States funded through the Kaiser Family Foundation to participate in the Quality Assurance Reform Initiative.

Managed Fee-For-Service Programs

The State has identified high users of medical services whom the State believes would be better serviced by having their health care managed. Such recipients are placed in a special recipient restriction program and their primary care providers case manage their use of medical services.

Minnesota uses a prior authorization system as one of its mechanisms for managing health care. In recent years, Minnesota has made an effort to increase the use of telephone prior authorizations to speed up the decision making process between the provider and the State. Prior authorizations are required for expensive items, unusual items, and items for which there is a high incidence of use.

Minnesota purchases many items in bulk, in an attempt to manage its health care costs. These items include eyeglasses, oxygen, and durable medical equipment.

CONTACT: Gary Miles, Director
Coordinated Care Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3854
(612) 296-2741

MISSISSIPPI

HEALTHlink

In January 1993, the Mississippi Division of Medicaid received approval of a waiver to implement a primary care case management program named HEALTHlink. Certain Medicaid recipients will choose and enroll with, or will be assigned to, a primary care provider (PCP) who will manage their health care needs through provision of primary care, after-hours coverage, appropriate referrals for specialty services, and authorization of most Medicaid services. The PCP will be paid a monthly case management fee of \$3.00 for each recipient enrolled, and the usual fee for Medicaid services provided. The specified Medicaid recipients must participate in HEALTHlink if they live in a county in which HEALTHlink has been implemented, unless excluded in certain circumstances.

HEALTHlink will be implemented on a pilot basis in seven counties prior to Statewide implementation. Enrollment is scheduled to begin in Washington County on August 23, 1993 for issuance of HEALTHlink Medicaid cards for October. Some recipients will be enrolled by automated means based on historical usage of participating Medicaid providers. Enrollment of most other recipients will occur over a period of six months at times of initial approval and regular or special redetermination of eligibility. There are about 32,000 HEALTHlink eligible recipients in the seven pilot counties.

Specified categories of Medicaid recipients who must participate in HEALTHlink are Aid to Families with Dependent Children (AFDC), four Medicaid-only programs that cover pregnant women and children, foster children, and children for whom adoption assistance is being provided. Initial implementation will cover recipients of AFDC and the programs for pregnant women and children for whom eligibility is determined by county Economic Assistance offices of the Mississippi Department of Human Services. These recipients will be enrolled at the county office by Economic Assistance workers. The other groups will be phased-in later since eligibility is determined by State office staff of the Division of Social Services, Mississippi Department of Human Services. Recipients will be enrolled by staff of that Division either at the county or State office.

Recipients in the above categories of Medicaid eligibility are excluded from participation in HEALTHlink if: 1) Medicaid eligibility is retroactive only; 2) recipient resides in a nursing or ICF/MR facility, or a mental hospital; 3) good cause

exists because the recipient has a pre-existing relationship with a physician who is not a HEALTHlink provider or travel time from the recipient's home or work to a HEALTHlink provider would be prohibitive.

HEALTHlink enrollees will have the same range and amount of services as other Medicaid recipients. However, there are some services that will not require the prior or post authorization of the PCP, but are obtained through the same procedure as used by other Medicaid recipients. These excluded services are dental, psychiatry, ophthalmology, optometry and eye glasses, podiatry, nursing home and ICF/MR, and general transportation and ambulance/wheelchair van. Although emergency services for a true emergency and family planning services are covered by HEALTHlink, these services do not require prior authorization by the PCP.

PCPs may be physicians who are family or general practitioners, pediatricians, internists, obstetricians, or gynecologists; physician group practices, federally qualified health centers, rural health clinics, and Health Department clinics; and pediatric, adult, and family certified registered nurse practitioners. All PCPs must be Medicaid providers in good standing. Individual physician PCPs and HEALTHlink physicians in a clinic/center must also have hospital admitting privileges. Certified registered nurse practitioners must be associated with a HEALTHlink physician who has approved the protocol.

PCPs may specify the number of HEALTHlink enrollees they will accept, as long as the number does not exceed the maximum number established by the Division of Medicaid. A physician provider may have no more than 1,500 enrollees; a certified nurse practitioner may have no more than 500 enrollees; and a clinic/center may have no more than 1,500 times the number of full-time equivalent participating physicians plus 500 times the number of participating certified registered nurse practitioners. The division of Medicaid may waive the upper limit on enrollees per PCP, if the PCP agrees, in order to secure adequate coverage or when other factors necessitate such action.

Prior to the beginning of each month, a PCP will receive a report of enrollees for the coming month. The report will list current enrollees with new enrollees flagged, and enrollees from the previous month who are no longer enrolled. Following the end of each month, the PCP will receive a report of Medicaid services provided his/her enrollees by other providers. The PCP will be responsible for reviewing the report and notifying the Division of Medicaid of any errors and/or any services reported that were not authorized. Utilization reports generated at least quarterly will compare the PCP to others of his/her specialty and with all other PCPs. These reports will be used by Division of Medicaid to determine whether medical audits/reviews are needed.

EPSDT

When HEALTHlink is implemented in a location, the PCP is responsible for providing or referring for EPSDT services. However, in other counties a physician provider may enter into a written agreement with the Division of Medicaid to provide continuing care services through the EPSDT program. The parent or other responsible party must agree in writing to participate in the continuing care arrangement that allows the physician to be the sole provider of EPSDT services. The designated screener will be the only EPSDT provider to receive payment for well child services. It does not prevent on-call relief or any other physician from being paid for emergency or any other physician charges.

A case management fee will be paid annually for maintaining the child's medical records and any reports from specialists to whom the child was referred from services not usually provided by the continuing care physician.

CONTACT: Judith Michael
Director of Managed Care
Division of Medicaid
Suite 801, Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201-139
(601) 359-6133

MISSOURI

Missouri currently has one §1915(b) waiver to provide managed care in Jackson County, Kansas City, Missouri, and has another waiver in development to establish managed health care in St. Louis City/County.

Missouri's existing 1915(b) waiver provides a health care delivery system for recipients of Aid to Families with Dependent Children (AFDC) whereby primary care services are provided by four prepaid health plans and approximately 36 individual physicians, called physician sponsors.

History

The program originally began under a four year Federal demonstration grant approved in July 1982. Actual enrollment into the program began in January 1984, with full enrollment achieved in the first quarter of 1985.

Enrollment

Enrollment in the Managed Health Care Program is mandatory for all AFDC determined eligibles. As individuals apply to receive AFDC, they attend a presentation of the Managed Health Care Program. Employees of the Department of Social Services, Division of Medical Services (DSS/DMS), explain the program guidelines and available options in order that a well-informed choice of provider can be made by each individual. Choice counselling presentations are monitored to ensure the information given remains complete, accurate, and unbiased. Individuals are encouraged to select the health plan or physician sponsor which will best meet their needs. As of July 1, 1993, there were approximately 40,045 individuals enrolled.

Physician Sponsor Option

Physician sponsors are independent physicians who have chosen through the Managed Health Care Program to act as case managers for their enrollees. They provide primary care and refer enrollees for specialty care and hospitalization as necessary. Physician sponsors are reimbursed on a fee-for-service basis, though they also receive an additional \$3.00 per enrollee per month for serving as the case manager. As of July 1, 1993, there were 8,336 recipients enrolled with 36 physician sponsors or 21% of the total eligible population.

Prepaid Health Plan Option

In the Managed Health Care Program, a prepaid health plan is a provider that offers health care at either one or several locations or at individual physicians' offices. The plan assumes contractual responsibility to provide or assure delivery of a stated range of services for its enrollees.

Each health plan is then paid a monthly capitation rate per enrollee based on age, sex, and historical utilization data. This payment is received by the plan regardless of whether the cost of actual services provided to their enrollees is less than or exceeds the capitation amount, thus, presenting the plan with a degree of financial risk. Therefore, it is to the plan's financial advantage to initiate enrollees' education regarding preventive health care and proper utilization of health care resources. Any services covered under the plan, but not provided directly by the plan, are furnished on a referral or subcontractual basis to another provider who is then reimbursed directly by the plan. As of July 1, 1993, four prepaid health plans serve 31,709 recipients or 79% of the total eligible population.

Quality Assurance

In order to sustain enhanced quality of care for the program's enrollees, the Managed Health Care Quality Assurance section employs a variety of methods, including monitoring contract compliance, review of grievances and transfer requests, audits of medical care, utilization reviews, and follow-up on satisfaction surveys administered to enrollees. Both the prepaid health plans and the physician sponsors are contractually required to furnish 24-hour-a-day, 7-day-a-week availability to their enrollees. At a minimum, this must be a telephone answering service with access to a physician on call to provide medical advice.

In accordance with federal regulations, guidelines concerning transfer have been set forth in order to maximize continuity of care for the enrollee. For those individuals who elect to become enrolled with three of the prepaid health plans, a transfer to another provider may be requested during the first 30 days of each six month enrollment period. Should a transfer be requested after the initial 30 day period, an enrollee must first comply with the health plan's established grievance process. If, in so doing, the enrollee's problem is not satisfactorily resolved, a transfer will be permitted. For those individuals enrolled with a physician, sponsor or with the remaining health plan, which operates as a locally supported public hospital, a transfer may be requested at any time. However, once an enrollee has transferred from a given provider, s/he may not re-enroll with that same provider for six months.

Since the program's inception, significant emphasis has been placed on enrollee education. The contracts contain language requiring that the health plans furnish documentation of their endeavors to educate their enrollees, thereby allowing the State a means of monitoring their efforts. This includes review and authorization by the State of all marketing materials and review of enrollee correspondence. On-site audits are also utilized as a direct contact with enrollees regarding the nature of education provided by the plans. This education not only helps ensure compliance with the program's guidelines, it allows enrollees to make the most efficient use of the program's benefits.

Cost Effectiveness

Based upon cost effectiveness reviews conducted since its inception, the program has averaged \$1.5 million in savings to

the State each year. As a result of the success of the program, Missouri is expanding the program to include the Medicaid for Children eligibility category in Jackson County.

CONTACT: Gary Bailey
Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500
(314) 751-6922

MONTANA

Montana Medicaid has a 1915(b) waiver to operate a primary care case management program called PASSPORT TO HEALTH. It was implemented in January, 1993. The goal is to implement the program statewide or in as many areas as possible. Outlined below are the major components.

Recipients. Initially, existing AFDC recipients in areas where enough primary care providers participate will be enrolled by mail. Existing recipients in a new county are enrolled by mail. New AFDC and AFDC-related recipients are enrolled when applying for benefits at the county office; new SSI recipients are enrolled by mail. Existing SSI recipients will be enrolled by mail in July, 1993.

Exempted from participation are recipients who: are medically needy, have Medicare, are in a nursing home or ICF/MR, have eligibility period of less than three months, live in an area excluded from the waiver, are only retroactively eligible, have TPL in which they are already enrolled in a coordinated care program, cannot find a primary care provider (PCP) who will accept them, can prove it would be a hardship to participate, are in subsidized adoption, or are receiving home and community based waiver services.

Recipients who do not choose a PCP will be mandatorily assigned one. Recipients may request a change in their PCP once a month; they need not have good cause. Recipients requesting more than two changes in a six month period will be investigated. PCP information will appear on the Medicaid card.

Providers. Providers eligible to be PCPs are: physicians (family practitioner, ob/gyn, pediatrician, internist, and any other physician who agrees to provide primary care), certified nurse practitioners, certified nurse midwives, physician assistants, federally qualified health centers, rural health clinics, and Indian Health Service clinics on a reservation. County health departments would be eligible if they can meet the criteria.

PCPs must agree to provide primary care (including EPSDT screens), refer for specialty care, and be accessible on a 24-hour a day, 7 days a week basis. They designate how many recipients they are willing to case manage. The upper limit is 1,500 for physicians and 1,200 for mid-level practitioners; there is no minimum. Providers may limit their PASSPORT enrollees to Medicaid recipients who are already part of their current caseload.

Services. The services that must be provided or authorized by the PCP are: inpatient and outpatient hospital, ambulatory surgical centers, physician, nurse specialist, EPSDT screens, federally qualified health center, rural health clinic, Indian Health Service clinic, EPSDT screens, chiropractic (an EPSDT service), and inpatient psychiatric treatment for individuals under 21.

In the categories of service requiring authorization, exceptions are obstetrical care, vision, outpatient mental health, family planning procedures, anesthesiology, radiology, and pathology. All other categories of service may be obtained without the PCP's authorization.

Referrals may be made verbally or in writing. The PCP authorizes a service by giving his or her Medicaid ID, Medicare UPIN or a PASSPORT provider number to the provider to whom the patient is referred. That provider must then put the PCP's number on the claims form in the appropriate filed.

Reimbursement. PCPs will receive the regular fee-for-service or cost-based reimbursement for services delivered. In addition, they will receive a \$3.00 per enrollee per month case management fee; that fee will be paid whether or not they saw each enrollee that month.

Advisory Council. The PASSPORT TO HEALTH Advisory Council has been meeting regularly since November, 1991. Members include representatives of physicians, clinics, nurse practitioners, physicians assistants, recipients, legal services, tribal health departments, mental health hospitals, county human service offices, and interested members of State government.

CONTACT: Sharon Donovan, Program Officer
Medical Support Section
Medicaid Services Division
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, MT 59604-4210
(406) 444-4540

NEBRASKA

Nebraska has neither a §1915(b) freedom of choice waiver program nor a contract with a prepaid health plan at this time. However, the State is in the process of development of an urban area prepaid, capitated venture, that is scheduled to become operational July 1, 1994.

CONTACT: Bob Seiffert
Medical Services Division
P.O. Box 95026
Lincoln, Nebraska 68509
(402) 471-9718

NEVADA

Nevada Medicaid has operated a PCCM program since November 1983. The PCCM functioned under a §1915(b)(1) waiver from November 1, 1983 until May 25, 1988. Since May 1988, Medicaid has contracted to provide care and service under a PHP pursuant to §1915(a)(1)(A). Nevada will submit a new 1915(b)(1) waiver request for a Statewide mandatory choice enrollment program. The new program will be called MAPNET.

At present there are three PCCM contractors. Nevada Medicaid contracts with the University of Nevada School of Medicine to provide care at two family practice sites, in Reno and in Las Vegas. In April 1992, a new provider "NevadaCare" contracted with Medicaid to provide services in Clark County (Las Vegas). In October the Community Health Center of Southern Nevada (an FQHC) agreed to contract with Medicaid's PHP program. All programs provide, either directly or through subcontract with appropriate parties, the following services:

- o all physician services to include: office visits, emergency visits, clinic visits, family planning, and inpatient care in both acute and nursing facilities;
- o Radiology and clinical pathology services (except those provided in an acute hospital); and
- o prescribed drugs (except those provided in an acute hospital).

All other medical services are reimbursed by Nevada Medicaid and are subject to Medicaid service limitations.

Enrollment in both health plans is voluntary at this time. Disenrollment may be requested at any time and is effective the first of the month following the request to disenroll.

Nevada Medicaid is primarily responsible for the marketing of the enrolled health plan. The program is marketed by welfare eligibility workers in the Reno area. In Las Vegas, Medicaid employs marketing specialists. These specialists conduct group marketing sessions in the welfare district offices.

As of July, the health plans had 16,815 enrollees from a total market of 50,511 eligible welfare recipients in the categorically needy AFDC and aged programs in the areas where the program is offered. Approximately 33 percent of the eligible population are enrolled. Nevada Medicaid plans to add child welfare and the disabled to the enrollee categories.

The medical professional staff conducts an annual audit at each program site. The auditors review for quality of care, access to care, follow-up, and evidence of the teaching of wellness concepts. There are quarterly studies to compare the cost and utilization of FFS Medicaid eligibles to the enrollees, by aid category, provider type, geographic area, age and sex.

Nevada Medicaid is presently negotiating with several PHP contractors for a variety of services.

CONTACT: Debbra J. King, CPA, Chief, Medicaid Program
Services
Nevada Medicaid
2527 North Carson Street
Carson City, NV 89710
(702) 687-3797

NEW HAMPSHIRE

The Division of Human Services has a contract with Matthew Thornton Health Plan, Inc. (MTHP), an HMO. Medicaid recipients who are categorically needy under the AFDC, Foster Care (FC), and Child Welfare Service (CWS) programs who reside in the Concord, Manchester and Nashua service areas are eligible to enroll in MTHP. Enrollment is on a voluntary basis. The Division of Human Services contracts with the New Hampshire Foundation for Medical Care, a professional review organization, to perform an external review of HMOs.

CONTACT: Diane M. Kemp, Program Specialist
Department of Health and Human Services
Division of Human Services
Office of Medical Services
6 Hazen Drive
Concord, NH 03301-6521
(603) 271-4365

NEW JERSEY

Current Coordinated Care Programs

The coordinated care programs for primary care in New Jersey include:

- 1) a State operated, public Health Maintenance Organization (HMO) known as the Garden State Health Plan (GSHP);
- 2) contracts with private HMOs; and
- 3) inclusion of community health centers as participating providers in the regular Medicaid program as well as medical case managers under the GSHP.

On July 1, 1991, Governor Florio signed into law Chapter 187 of Public Law 1991, the Health Care Cost Reduction Act. This law requires:

- 1) a five-year plan to develop a statewide network of managed care providers for Medicaid recipients which would include
 - o The GSHP, and
 - o any other State approved or federally qualified HMO, or any other cost effective health plan, prepaid or otherwise,
- 2) every State approved or federally qualified HMO to submit a plan to enroll Medicaid recipients, and
- 3) the GSHP to offer coverage to persons who are not eligible for Medicaid and are employed either on a full-time or part-time basis and do not have health insurance coverage by the employer or spouse's employer, or cannot afford health insurance offered by the employer or spouse's employer. In addition, small employers who have not offered health insurance coverage to their employees anytime during the 12 month period immediately preceding the effective date of coverage shall be eligible to purchase coverage through the GSHP.

GSHP. GSHP, a public HMO, is administered through the Office of Managed Health Care Programs and is a subdivision of the single State agency, the New Jersey Department of Human Services through the Division of Medical Assistance and Health Services (DMAHS). DMAHS administers the Medicaid program and provides services as set out in 42 U.S.C. 1396b(m)(A)(i) and is organized pursuant to 42 U.S.C. 1396b(m)(6). The GSHP is organized primarily for the purpose of providing health care services through a medically case-managed system. Participation in the Plan is voluntary for

Medicaid eligible members and physicians.

Administratively, the GSHP is organized as an HMO, with administrative, financial, marketing, medical, management information systems and plan relations staff. In addition, the Plan has several outside advisory committees including two committees for Quality Assurance: Quality Assurance Advisory Committee (comprised of community providers) and the Division's Medical Quality Assurance Committee.

The Plan is currently open to Medicaid eligible individuals with the following categories of assistance: AFDC; other children under age 21, including Medicaid Special, and those in foster care and adoption assistance under the Division of Youth and Family Services supervision; SSI Aged, Blind and Disabled; JOBS Medicaid extensions through the sixth month of extension; Community Medicaid Only (non-institutionalized aged, blind, and disabled) and individuals in New Jersey Care...Special Medicaid Programs, except Medically Needy. Plan members may receive one six month period of guaranteed eligibility.

The GSHP contracts directly with physicians in the community. Any licensed physician, Medicaid participating physician, MD or DO, licensed to practice medicine and surgery, meeting the Plan credentialing requirements and providing services through a free-standing, independent practice, may apply as a physician case manager. In general, pediatricians, family and general practitioners, internists, and obstetricians/gynecologists are the physicians who participate as case managers.

Participating physician case managers (PCM) are reimbursed on a capitation basis and must provide for primary care and coordinate all the health care needs of the members enrolled with them including referral to physician specialists and other health care practitioners, ancillary services, and inpatient care. Under the Plan, the PCM must provide for Plan services 24 hours a day, seven days a week.

Plan members are entitled to a managed care package of medical services which include comprehensive preventive, diagnostic, rehabilitative, and therapeutic health care services in addition to all other Medicaid services.

The GSHP currently has a Certificate of Authority to operate in 10 of the 21 counties in New Jersey. The counties are: Atlantic, Burlington, Camden, Essex, Mercer, Middlesex, Morris, Passaic, Sussex, and Union. The GSHP will be expanded statewide. The GSHP is in the process of expanding its Certificate of Authority to operate Statewide.

The New Jersey Division of Medical Assistance and Health Services contracts with the Peer Review Organization of New Jersey to do independent, annual quality assurance reviews of the GSHP in

accordance with §1903(m)(6).

Private HMO Contracting. Currently, the New Jersey Division of Medical Assistance and Health Services has a contract with one private, staff model HMO which is Federally qualified. The program is administered through the Office of Managed Health Care Programs. Staff are responsible for: negotiating contracts and capitation rates; arranging for the determination of eligibility; authorizing payments to the HMO; monitoring contract performance including quality assurance/utilization review, financial status, and general contractual obligations; acting as liaison and advocate for the Medicaid enrollees; and providing technical support to the HMO.

The current contract is limited to the AFDC population. In the current negotiated contract the HMO has expanded to five additional counties, so that the HMO is now serving Medicaid members in a total of eight New Jersey counties -Burlington, Gloucester, Hudson, Mercer, Bergen, Union, and Camden and Middlesex.

Categorically, the service package under the HMO contract is broad but does include several limitations to services in duration and scope. As under the GSHP, Medicaid enrollees are entitled to the managed care package of medical services which include comprehensive preventive, diagnostic, rehabilitative, and therapeutic health care services. In addition, Medicaid enrollees are entitled to all other Medicaid services not included under the HMO benefit package. A guarantee of Medicaid eligibility is made available to Medicaid enrollees and the HMO may utilize the lock-in provision if desired.

The New Jersey Division of Medical Assistance and Health Services contracts with the Peer Review Organization of New Jersey to do independent, annual quality assurance reviews of the private HMO in accordance with §1902(a)(30)(C).

Interest in Medicaid participation by private HMOs has grown in the past year. The Division is currently negotiating contracts with two private HMOs and is providing assistance to several other HMOs regarding the contracting process.

The plans submitted by HMOs to enroll Medicaid members as required by Chapter 187, P.L. 1991, the Health Care Cost Reduction Act have been reviewed and analyzed. These plans are also used as the first step in the contracting process.

Community Health Centers (CHCs). CHCs have participated as Medicaid providers for many years. Several CHCs also participate as physician case manager sites in the GSHP. CHCs provide services to all eligibility categories and participate in the special Medicaid programs in New Jersey such as HealthStart,

EPSDT, and New Jersey Care...Special Medicaid Programs, including Medically Needy.

There are currently three active CHCs participating as physician case manager sites in the GSHP: CamCare CHC in Camden County, Eric B. Chandler CHC in Middlesex County, and CHC of Paterson in Passaic County.

As GSHP medical case managers, the CHC physicians must provide for primary care and coordinate referrals for specialty, ancillary, and inpatient care included under the GSHP.

Under the GSHP, CHCs are subject to monitoring by the State and independent quality assurance review by the State's outside contractor.

Other qualified CHCs will be outreached for participation as GSHP physician case manager sites as the Plan expands its provider network.

CONTACT: Judith A. Champion, Executive Director
Office of Managed Health Care Programs
Division of Medical Assistance and Health Services
CN 712
Trenton, NJ 08625-0712
(609) 588-3580

Daniel Walsky, Executive Director
Private HMO Contract Management Team
Division of Medical Assistance and Health Services
CN712
Trenton, NJ 08625-071
(609) 588-3699

NEW MEXICO

New Mexico has begun implementation of its Primary Care Network (PCN) under a §1915(b)(1) waiver. At this time, all of our coordinated care activities are contained within this program. The following is a description of the program followed by a brief status report.

PCN Program Description (07/22/93). The Human Services Department has developed a Primary Care Network, a system which is improving management of medical services provided by the Medicaid program. Each Medicaid recipient in the PCN must choose a primary care physician or clinic who will be that patient's first resource in obtaining health care. Each recipient must also choose a primary pharmacy, which will be his/her source for non-emergency prescriptions.

The PCN is modelled after successful programs in Kentucky, Colorado, and other States. The PCN pays each participating primary care physician a \$2 monthly management fee for all Medicaid-eligible patients in the physician's care. This fee is in addition to the normal fees for medical services, and is paid regardless of whether the patient uses services in that month.

Goals of the PCN

Improved Quality of Care. The PCN improves continuity of care and strengthens the positive relationship between the Medicaid patient and the physician. It provides each Medicaid-eligible person with a source for primary care and early treatment of health problems. It encourages patients to build a lasting patient-doctor relationship, so that the primary care physician can become familiar with the patient's medical history and related health conditions. A monthly report to the physician allows each physician to compare his or her practice to the average of his or her peers, on measures such as the number of prescriptions written and the number of hospital admissions per 100 patients.

Establishing the Physician-Patient Relationship. Each Medicaid recipient is requested to join PCN by choosing a primary care physician or clinic from the list of those in their area. PCN members may change physicians at any time by written request, effective when their next Medicaid card is issued. Each change will remain in effect for a minimum of six months before the recipient may request another change. A recipient who wishes to change physicians immediately may do so by obtaining approval from the Department. PCN members who repeatedly request to change providers may be denied the request, and may be targeted for review. Recipients who have no family physician will be offered a list of those available to help in selecting one.

Improved Access. The PCN encourages participation by physicians who have been currently reluctant to serve the "difficult" Medicaid population. Because PCN improves the physician's ability to manage his/her patients, the program has had considerable success in enrolling physicians who had previously accepted few, if any Medicaid patients. This same characteristic has facilitated the enrollment of BIA and FQHC providers in rural areas around the State. Specialists have been more willing to accept a Medicaid patient who was referred by a colleague than one who walked in without a referral.

New Mexico has a serious shortage of physicians in rural areas. Roy Butler, Kentucky Commissioner of Medicaid Services, has said that Kentucky's primary care network has encouraged some new doctors to settle in rural areas where there is a ready-made patient load.

Increase Access to Prenatal Care. Obstetrician-gynecologists may be primary care providers, and will be expected to provide prenatal care and other obstetrical care for their PCN enrollees. However, obstetrical services are excluded from PCN restrictions because the Department wants to ensure that no barriers are placed before women who seek prenatal care. This area of health care is troubled by underutilization, not overutilization. For prenatal care, the Primary Care Network will serve as an access point rather than as a gatekeeper.

New Mexico now ranks 49th among all fifty States and the District of Columbia in the percentage of pregnant women who receive early and continuous prenatal care. The Human Services Department is taking several actions to improve access to prenatal care, including:

- o working directly with the New Mexico Medical Society to increase provider availability;
- o introducing presumptive eligibility Statewide;
- o introducing prenatal care case management programs in eight counties; and
- o undertaking a Statewide maternal and child health outreach and education medica campaign.

New Mexico has a statewide program providing presumptive eligibility determinations for pregnant women. Certain providers are authorized to provide limited prenatal care to women who are presumed to be eligible for Medicaid based on a preliminary screening. That is, Medicaid will reimburse for these limited services even if the woman is later determined ineligible through the usual application process. Women receiving services through presumptive eligibility will select a primary care provider after they become eligible for Medicaid through the application process.

Program Integrity and Cost Containment. The PCN has been cost-effective because it has reduced over-utilized services and strengthen the Medicaid program's integrity. It has reduced unnecessary "doctor shopping". PCN discourages multiple treatments for a single medical problem. It also discourages overuse of medication by problem patients, who otherwise might visit several doctors, seeking to obtain extra prescriptions.

PCN produces monthly management reports which the physician can use to compare his/her practice with others in the same field of medicine. These reports go to all primary care providers. Primary care providers who have a history of overutilizing services will be targeted for review and may be excluded from PCN.

PCN complements some functions now handled by the Medical Management program. When fully implemented PCN will link about 80 percent of the Medicaid recipients to a physician and a pharmacy selected by the recipient. However, Medical Management will still review recipients who use services inappropriately, and may "lock in" the recipient to a physician and a pharmacy or a specialist. By monitoring overall utilization and the number and types of changes made by recipients, PCN can serve as an early warning of possible utilization problems which require closer scrutiny by Medical Management staff.

Structure of the PCN

The Primary Care Providers's Role. The primary care physician or clinic is the patient's entryway into the health care system. He or she provides basic health care such as office visits and prescriptions for medications. The primary care provider makes all necessary referrals to care by specialists such as cardiologists and surgeons. The primary care provider receives a small administrative fee for maintaining their patients' records, and the usual Medicaid fees for all other services provided.

Referrals may be made verbally or in writing at the primary care provider's discretion. The secondary provider indicates the primary care provider's Medicaid number in the box marked "Referring Physician" on the claim form. No paperwork is necessary. The PCN staff monitor referral patterns to ensure that provider numbers are being used appropriately and not automatically.

The Primary Pharmacy's Role. The primary pharmacy is the patient's sole source for non-emergency pharmacy services. The pharmacist monitors all prescription drugs being used by the patient. This program strengthens the pharmacist's ability to prevent adverse interaction between drugs, to avoid overlapping renewals of prescriptions, and to counsel patients on appropriate utilization of prescription drugs. Emergency prescriptions, like other emergency services, may be provided by any qualified Medicaid provider.

The Patient's Role. Each recipient selects his/her own primary care physician from the list of participating physicians in the area. Each recipient selects a pharmacy in a similar process. Recipients who do not select a physician are assigned to the primary care provider from which they most recently received services. Those who have not received services in the past six months are assigned to a physician appropriate to their age and sex in rotation. Recipients are given training materials on how to use the health care system, including personal responsibility and lifestyle, relationships with primary care providers, and appropriate use of specialists, prescription drugs, and the

referral process.

Provider Participation. Primary care providers may be Medicaid-participating general practitioners, family practitioners, internists, pediatricians, and obstetrician-gynecologists, or clinics which include any of the above. The Department has contacted all of these physicians currently licensed in the State, inviting them to become Medicaid providers if they are not currently, explaining the PCN to them, and asking them to participate in PCN. The primary care provider agreement will be similar to those used in Kentucky and Tennessee. PCN staff members routinely contacted new providers by telephone to explain PCN and invite them to enroll. Each PCN physician or clinic must agree to the requirements specified in the PCN Provider Agreement.

Each physician may accept up to 1500 PCN patients, or may specify a number between 50 and 1500. Clinics will be allowed to accept up to 1500 patients per full-time equivalent physician. Physicians who supervise advanced registered nurse practitioners or physician's assistants will be allowed to accept up to 300 additional patients per nurse practitioner or physician's assistant.

Recipients may select as their primary care pharmacy any Medicaid-participating pharmacy in their PCN area. Primary care pharmacies will not be required to contract with the Department to provide services, because no services are required beyond the pharmacy's present role. Pharmacies may serve any number of recipients. Recipients may only change pharmacies once every six months.

Recipient Participation. All Medicaid recipients will be required to join PCN, with limited exemptions. Newly eligible persons, those who move to a new county, and those whose primary care provider becomes unavailable will be exempt for 60 days while they select a primary care provider. Persons eligible for both Medicaid and Medicare will be exempted. Recipients who are restricted to certain physicians by a third party payor such as an HMO will be exempted. Recipients who have a legitimate reason for exemption, such as those who are already in the ongoing care of a specialist, may apply for and receive exemption.

Medicaid recipients will be asked by direct mail to select a primary care provider from the list of those in their county. The direct mail campaign will consist of a computer-generated mailing explaining PCN, including the list of primary care providers in the county, a statement identifying the primary care provider to whom the recipient will be assigned if the recipient does not select one, and a prepaid mailer for the recipient to return.

In spite of patient education efforts, some number of PCN members will incorrectly visit a physician other than their primary care provider, and will learn only then that they must visit their primary care physicians to receive Medicaid services. The Medical Assistance Division will provide both physicians and the Income Support Division offices with assistance in resolving these problems.

Categories of Service. Medicaid services will fall into three categories:

1) services provided by the primary care provider under the primary care provider agreement, including:

- o primary care health services;
- o referrals for other health care services covered under PCN;
- o 24-hour coverage;
- o reviewing utilization reports;
- o notifying the Department of any patient misutilizing services; and
- o maintaining the patient's medical records.

2) services covered under PCN which must have a referral from the primary care provider, including:

- o specialist services and other physician services, including urgent care;
- o hospital inpatient and outpatient services;
- o ambulatory surgery; and
- o rural health clinic services.

3) services which are exempt from PCN and which may be provided by any qualified Medicaid provider, including:

- o eyeglasses and related services;
- o dental services;
- o psychiatric services;
- o obstetrical services;
- o family planning services;
- o "free standing" laboratory and radiological services;
- o nursing home, home health, and ICF/MR services;
- o services provided by the Indian Health Service;
- o emergency room services and ancillary services;
- o hospital visits by physicians;
- o dialysis;
- o audiology; and
- o anesthesia.

Program Implementation

HCFA approved the waiver for the PCN in October 1989, and the New Mexico State Legislature approved staff and funding for the program starting in July 1990. PCN is currently active in 23 of New Mexico's 33 counties. An additional three counties will be added by December 1993. It is anticipated that all counties will be participating by March 1994.

PCN Status Report. HCFA approved the waiver for the PCN in October 1989, and the New Mexico State Legislature approved staff and funding for the program starting in July 1990.

On October 31, 1993 PCN will complete the original waiver period. A waiver renewal application including an independent evaluation of PCN by the University of New Mexico has been submitted for approval by HCFA.

Although the overall program concept and structure remains intact, the renewal application contains proposals to lengthen the lock-in period from six months to one year and to exclude the following services from PCN restrictions: "all services provided by Indian Health Services (IHS), anesthesia," "audiology," "dialysis," "nursing home," Intermediate Care for the Mentally Retarded (ICF/MR)" and "home health services," hospital visits by physicians," and "free-standing laboratory and radiological services."

PCN is currently serving 80,000 recipients in 23 counties of the 33 New Mexico counties. The network includes 821 physicians practicing individually or in clinics, 304 pharmacies and 140 Licensed Nurse Practitioners and Physician's Assistants. An additional three counties will be added by December 1993. It is anticipated that all counties will be participating by March 1994.

Quality Assessment. The independent evaluation conducted by UNM found that --despite significant PCN savings (detailed below)-- the PCN enrolled population had a significantly higher rate of overall Medicaid usage than the non-PCN population, 74.5% to 58.6% respectively. The report concluded "It seems plausible . . . that much of [the] savings is due to the increased emphasis on primary care and early intervention under PCN."

The evaluation reported that 44.8% of all physicians sampled rated PCN "above average" or "excellent," with another 41.4% rating it "average." More than 76% of the recipients sampled stated that they were "satisfied" or "very satisfied" with PCN.

Program Costs to Date. In the recent waiver renewal application New Mexico PCN reported total program costs of \$454,089,763 for the waiver period. This includes \$450,563,526 in program benefit

costs and \$3,526,237 in PCN related administrative costs and PCP management fees.

PCN Savings. The recent waiver renewal application shows total net program savings of \$47,869,559 for the initial waiver period. The UNM evaluation shows "net" savings (minus case management fees) of \$53,170,217.

CONTACT: Joel Hopko, Supervisor
Primary Care Network Unit
New Mexico Human Services Department
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348
(505) 827-4377

NEW YORK

Legislation passed in 1991 focuses greater attention on the managed care effort by establishing a statewide managed care program with specific enrollment goals for local district managed care programs. Enrollment goals for local district managed care programs are:

- o 10% of the district's Medicaid population who are not exempt from participating in the managed care program within one (1) year of the managed care plan approval;
- o 25% of the district's Medicaid population who are not exempt from participating in the managed care program within three (3) years of the managed care plan approval; and
- o 50% of the district's Medicaid population who are not exempt from participating in the managed care program within five (5) years of the managed care plan approval.

In 1991, the New York State Department of Social Services designated twenty (20) local districts for submission of managed care plans to achieve the above enrollment goals. The second twenty districts were designated in 1992 for submission of managed care plans by May 1, 1993. These plans contain a variety of service delivery systems and reimbursement models: health maintenance organizations (HMOs), prepaid health services plans (PHSPs), physician case management programs (PCMPs) and clinic-based models. Regulations are being developed for the inclusion of the special care population (e.g. mental health, mental retardation and developmental disabilities, substance abuse) in managed care.

Currently, 18 local districts have exceeded year 1 (10%) enrollment goals, and one local district has exceeded year 3 (25%) enrollment goals.

As of July 1993, there are 72 managed care contracts in New York State. These include 57 HMO contracts, seven PHSPs, seven partially capitated programs, and one case management plan. The HMOs and PHSPs are risk comprehensive full capitation reimbursement models and the partial capitation models are PCMPs with the primary care physicians at risk for delivery of primary care services. Enrollment in these plans as of July 1993 is 210,557.

As of July 1, 1993, there are 30 additional contracts in various stages of development. We anticipate these contracts will be operational by January 1, 1994. These include 22 HMOs, three PHSPs and five partial capitation plans.

The partial capitation plans being developed are Article 28 comprehensive Clinic Model programs, which are expected to enroll approximately 16,000 MA recipients in all categories of assistance except Supplemental Security Income (SSI) and recipients eligible as a result of spenddown. A 1915(b) Federal waiver is in development to allow New York to share savings with these providers.

While the population served varies by contract, all programs serve the Aid to Families with Dependent Children (AFDC) population. Thirty counties in New York State have operational plans. This represents a geographical catchment area of more than 1/2 of the State.

External review of the HMOs and PHSPs for quality assurance is performed by the Island Peer Review Organization (IPRO) which is overseen by the Network State Department of Health.

An assessment of the State's implementation of the Medicaid Reform Act of 1984 is detailed in a report to the State Legislature (January 1990). Its preliminary conclusions note that access, continuity of care, quality of care and cost containment appear to have been achieved in the PHSPs and PCMPs operating prior to 1987. A similar stand-alone evaluation was conducted on the PCMP in Erie County which reached the same conclusions.

In Broome County, a physician enhanced fee-for-service (FFS) reimbursement model demonstration program was implemented in September 1991. Enrollment in this demonstration, as of July 1, 1993, is 1,631. Under a Federal waiver, physicians in this program (primary care and specialists) receive enhanced fees for each visit. All referred services (e.g. pharmacy, lab) must be authorized by the enrollee's primary care physician. Utilization

review and quality assurance will be conducted by a case management organization. Currently, a 1915(b) waiver is being developed to share program savings with recipients by adding dental services to the program's current benefit package. This waiver will initially include dental services for approximately 1,000 children, with benefits for adults to be implemented in the future.

New York's Southwest Brooklyn Managed Care Project is an approved 1915(b) waiver of freedom of choice, which began voluntary enrollment in October, 1991, and mandatory enrollment in October, 1992. This waiver was originally implemented to manage Medicaid recipients' health care through five HMOs and one PHSP. In December 1992, two additional HMOs joined the demonstration. New York City anticipates an enrollment of approximately 31,000 AFDC recipients and 250 primary care physicians. Current enrollment is approximately 18,000. The State also projects savings of \$580,182 in the first 2 years of operation. This projected savings is based on a 95 percent capitation rate of the estimated FFS costs. New York anticipates a significant increase in the availability of health care services to Medicaid recipients as a result of the implementation of this program in an area which has historically suffered from lack of access to primary care for its poor.

Other developments in New York City include implementation of a PCMP in Manhattan with a monthly capitation payment for all physician services (primary care and specialist). This program began in August 1992 and currently has 2,846 recipients enrolled. The program is sponsored by the county medical societies, which are currently developing similar programs for implementation in Bronx, Queens and Brooklyn. These programs will play a significant role in the New York City plan to enroll 50% of its Medicaid population in managed care.

CONTACT: James Wray
Department of Social Services
40 North Pearl Street
Albany, NY 12243
(518) 473-5600

NORTH CAROLINA

The Medicaid program in North Carolina presently has two alternative care programs: a comprehensive medical care plan with Kaiser Permanente Health Plan of North Carolina and Carolina ACCESS, a care coordination program.

Kaiser Permanente. The first managed care program was initiated in 1986 when we signed a prepaid contract with Kaiser Permanente

(Kaiser). Kaiser is a Federally qualified HMO and the prepaid contract has been a part of our State Health Plan. The program is available in three counties and serves the AFDC category. The three counties that are participating in Kaiser are: Durham, Mecklenberg and Wake. Participation in Kaiser is voluntary and the present enrollment is just under 3,500.

For those recipients who elect HMO coverage, Medicaid pays their HMO premium. Kaiser offers all of the regular Medicaid benefits except dental care. The standard Medicaid service limitations do not apply to Medicaid recipients enrolled with Kaiser. There is a Kaiser Representative in the Department of Social Services for each county who is responsible for educating and enrolling the recipients in the program.

Overall, the Kaiser program is successful in these counties and we have encountered minimum problems. External annual reviews are conducted by the Peer Review Organization in North Carolina. In the past, other HMOs in our State have been unwilling to serve the Medicaid population. We continue to communicate with other prepaid plans who are now considering Medicaid clients as participants in their health care program. HMOs usually serve larger and more densely populated communities which leaves much of our rural State without an HMO option.

CONTACT: Nancy O'Dowd
Division of Medical Assistance
P.O. Box 29529
1985 Umstead Drive
Raleigh, NC 27603
(919) 733-6964

Carolina Access. In April 1991, we began our managed care program called Carolina ACCESS--North Carolina's Patient Access and Coordinated Care Program.

The program has been implemented in 17 counties so far and our intention is to expand statewide in the next two years. Approximately 85,000 recipients are enrolled in the program as of August 1993.

Carolina ACCESS encourages more efficient arrangements for delivering care by linking Medicaid recipients with primary care physicians. Eligible recipients enroll with the participating primary care physician or clinic of their choice. This enrollment process is completed over a six month period during recipient certification and recertification. Carolina ACCESS contracts with primary care physicians in participating counties to coordinate their enrollees' health care needs by providing or arranging:

- o primary care services, including prevention, health maintenance, and treatment of illness and injuries;
- o referrals for specialty and for other covered services; and
- o after-hours coverage to needed primary care and referral services.

The Carolina ACCESS primary care physicians become the "gatekeepers" to their enrollees' health care services. Participating primary care physicians receive, in addition to normal Medicaid payments, a monthly coordination fee of \$3 per enrollee for the first 250 enrollees. For each additional enrollee over 250, the physician is paid a coordination fee of \$2.50 per enrollee per month.

Primary care physician participation includes family practitioners, pediatricians, obstetricians, general internists, and general practitioners. In addition, physician group practices, rural health centers, community health centers, health department primary care clinics, and hospital outpatient clinics may also be enrolled as a primary care provider. Participating physicians can set enrollment limits with a maximum limit of 1,200 enrollees per physician and 600 enrollees per physician's assistant or nurse practitioner.

This program is a mandatory program for certain categories of Medicaid recipients: AFDC; AFDC Related Groups; Medicaid Indigent Children (MIC); and Aged, Blind, and Disabled. Recipients who are also Medicare eligible have the option to enroll in Carolina ACCESS. Excluded from participation in Carolina ACCESS are individuals who are in mental hospitals, long term care facilities, personal care homes, foster care or subsidized adoption, domiciliary care facilities, and refugees.

The Department of Social Services in participating counties receive funds to establish a Carolina ACCESS Program Representative to coordinate the day-to-day operation of the program and to provide the necessary backup and training support within the county. We have focused on the need to change patterns of healthcare delivery through educating the recipients at every opportunity. Several different types of educational material and brochures have been developed for this purpose.

Monthly and quarterly utilization reports are being monitored to assess the program's impact on access, quality of care, and cost savings. The initial response to this program has been very

positive and participating counties are being selected based on their interest and commitment to the program and the willingness of primary care physicians to participate in Carolina ACCESS.

CONTACT: Nancy O'Dowd
Division of Medical Assistance
P.O. Box 29529
1985 Umstead Drive
Raleigh, NC 27626-0529
(919) 733-6964

OHIO

Health Maintenance Organization

The Ohio Department of Human Services (ODHS) is the single State agency with responsibility for the implementation and administration of the Ohio Medicaid Program. In an effort to enhance the level of access, quality, and continuity of care as well as to increase the predictability of Medicaid costs, ODHS has contracted with HMOs since 1978 for the provision of managed-care services to eligible persons under the Aid to Dependent Children (AFDC) program. The current total AFDC Medicaid population in Ohio is 1,070,065; HMO enrollment is approximately 15% of the total and 27% in the counties where Medicaid-HMO enrollment is available. The Ohio Medicaid HMO program is administered by the Managed Health Care Section in ODHS. The Section is responsible for contract development and monitoring, the writing and implementation of policies and procedures, resolution of enrollment and payment discrepancies, fiscal activities, and quality assurance/utilization review.

The Ohio Medicaid HMO Program is comprised of two components. The first component is a voluntary enrollment program with 9 participating HMOs serving 114,088 AFDC Medicaid eligibles in 13 counties as of June 30, 1993. HMOs market directly to eligible individuals and families. Enrollment forms are completed and sent to the corresponding County Department of Human Services (CDHS) for entry into the State computer system. This enrollment generates a monthly capitation payment to the HMO and halts the regular Medicaid card the eligible person would normally receive.

Enrollment continues until the eligible person elects to disenroll from the HMO, changes HMOs, or loses his/her eligibility for Medicaid coverage. Disenrollments are effective at the end of each month, subject to monthly cutoff dates required in order to process recipient data and changes for the following month. All enrollments and disenrollments are effective at the beginning of a month.

The second component of the HMO Program is the mandatory-enrollment program currently operating in Montgomery County.

This program covers 44,596 Medicaid AFDC and related eligibles in three HMOs (as of June 30, 1993). Recipients select from one of the three HMOs when applying for benefits.

In order to implement the mandatory program in Montgomery County, ODHS was required to apply to the Health Care Financing Administration (HCFA) for waivers of certain Federal requirements governing the Medicaid program.

Specifically, section 1915(b) waivers were required to permit ODHS to: (1) implement the mandatory program on less than a Statewide basis; (2) require recipients to select an HMO for enrollment; (3) offer additional services such as primary case management and preventive care services on less than a Statewide basis; and (4) pay subcontractors at a rate which exceeds projected fee-for-service (FFS) costs as long as total payments do not exceed equivalent total FFS costs. The Montgomery County mandatory-enrollment program went into effect in May 1989. The waiver has been renewed and is approved through January 31, 1994.

Currently, ODHS pays each HMO a pre-determined, monthly capitation payment for each Medicaid enrollee. The HMO is at financial risk for the entire range of Medicaid-covered services (except long term care including inpatient hospital. ODHS does limit the HMO's liability for inpatient hospital and related home health services through stop-loss coverage that is activated when an enrollee incurs single or aggregate hospital and home health claims that exceed \$20,000 for State fiscal year (SFY) 1993, and \$30,000 for SFY 1994. ODHS covers 85% of the amount in excess of the deductible.

Quality Assurance

The Ohio Department of Human Services monitors the quality of care delivered to Medicaid beneficiaries enrolled in HMOs through:

- o An annual quality assurance (QA) evaluation performed by an external contractor that includes a medical record audit, provider site facility reviews, and a corporate HMO review.
- o A quarterly review of all aspects of HMO operations and service provision.
- o A quarterly review of service utilization statistics.

This process enhances ODHS' ability to oversee and assure the effectiveness of activities which individual HMOs monitor, and improve the quality of care delivered to Medicaid enrollees.

Utilization Review

Unlike the FFS system, in which ODHS collects encounter data using claims submitted to the department, the HMO program collects aggregate encounter data from the HMOs using utilization forms. HMOs submit data quarterly based upon their collection of encounter information from providers.

Quality Assurance Reform Initiative (QARI)

In February 1993, Ohio was selected as one of three States to participate in the two-year QARI demonstration. QARI will test quality assurance reforms in Medicaid managed care which were developed by HCFA, State officials, HMOs, and consumer advocates.

Future Program Directions

The State's biennial budget bill requires ODHS to expand the mandatory managed care program to three additional counties: (Hamilton) (Cincinnati), Lucas (Toledo), and Franklin (Columbus). At least one of the counties must be mandatory by January 1, 1995, with all three programs implemented by July 1, 1996. All non-aged, blind, or disabled Medicaid recipients in these counties will be required to enroll in an HMO. At least three Medicaid-serving HMOs must be available in each county.

The Department has also been selected as a demonstration site for the Medicaid Working Group. This project, funded by the PEW Charitable Trusts and Robert Wood Johnson Foundation, will enroll specified groups of disabled Medicaid recipients in HMOs.

Ohio is also considering the feasibility of partial capitation arrangements, especially for the expansion of managed care into rural areas where Medicaid-serving HMOs may not be viable.

CONTACT: Cynthia Burnell, Chief
Managed Health Care Section
Ohio Department of Human Services
30 East Broad Street
Columbus, OH 43266-0423
(614) 466-4693

OKLAHOMA

A legislative task force was created following the SFY '92 session to develop recommendations for the reform of the State's Medicaid program. The following presents the specific recommendations of the Task Force with regard to the development of a managed care program for Oklahoma's Medicaid population.

A five year phased implementation approach was recommended for transitioning the State's current fee-for-service Medicaid system to a managed care program. The program would provide for mandatory enrollment of all Medicaid recipients in managed care plans according to the following schedule:

AFDC and non-institutionalized	50% in year 1
Medically needy population	50% in year 2
(SOBRA eligibility categories)	

Aged, Blind and Disabled recipients	Year 3
-------------------------------------	--------

Institutionalized populations (long term care) and the seriously and persistently mentally ill (SPMI)	Year 5
---	--------

A public-private partnership between the State and the health care industry would involve the use of full and partial capitation models to service the medical needs of the State's Title XIX population on a competitively bid basis.

During the SFY '93 session, House Bill 1573 created the Oklahoma Health Care Authority. The purpose of the Authority: to (1) purchase State and education employees' health care benefits and Medicaid benefits and (2) study all State-purchased and State-subsidized health care systems and (3) make recommendations and changes aimed at minimizing the financial burden on the State, its employees and charges while allowing the State to provide the most comprehensive health care possible.

Effective July 1, 1993, the Authority is charged with developing a plan to convert the Medicaid program to a managed care system, including a capitated pre-paid system and emphasis on primary and preventive care. On January 1, 1995, the Authority will become the designated State agency for the administration and delivery of the State Medicaid Program. The Authority will contract with the Oklahoma Department of Human Services for the administrative functions of the Medicaid program as necessary.

CONTACT: Jim Hancock, Field Representative
Program Development and Budget
Medical Services Division
Oklahoma Department of Human Services
Oklahoma City, OK 73125
(405) 557-2539

OREGON

Current Coordinated Care Programs

Primary Care Case Management (PCCM). Since December 1984, under sections 1915(b)(1) and 1915(b)(4) of the Act, the State of

Oregon has operated its PCO waiver program in which Medicaid AFDC recipients residing in Oregon counties are enrolled into a Physician Care Organization (PCO), unless they voluntarily elect to participate in an HMO.

The goal of Oregon's program has been to guarantee access to primary care and specialty physicians, and to improve the cost effectiveness and efficiency of the Medical Assistance program through use of partially-capitated and fully capitated health plans. This has been achieved through contracting with PCOs and federally-qualified HMOs. Oregon's PCOs may be individual physicians or groups of practitioners who provide and/or arrange for most of the health care services for recipients enrolled with them.

Under the waiver program, the PCOs are paid a capitation rate to cover at a minimum, physicians services, outpatient laboratory and X-ray services, and EPSDT services. COBRA 1985 permits Oregon to require PCOs to provide up to five services. A number of optional services may also be reimbursed on a capitated basis, if agreed to by the PCO and the State. Non-capitated services are paid on a fee-for-service basis, and PCOs which achieve savings on inpatient and outpatient hospital costs and drug costs share in the savings up to an agreed upon limit.

PCOs must demonstrate the ability to deliver or arrange for all necessary health care services for their enrollees. The State requires at least one primary care physician for every 1200 enrollees, and in the new counties being brought under the waiver enrollment is voluntary until capacity is assured. PCOs must also provide 24-hour telephone coverage, be accessible within 30 minutes travel time by public transportation for area recipients, and have bilingual staff where a substantial number of non-English speaking households are enrolled.

In the current waiver period Oregon estimates savings of about \$17,000,000. Oregon has received federal approval for demonstration waivers to implement the Oregon Health Plan (OHP). Under the OHP managed care enrollment will more than double and will include individuals up to 100% of FPL. Pregnant women and their children (up to age 6) with incomes up to 133% of FPL will also be covered. The OHP will be implemented February 1994 and will primarily be delivered through HMOs and other State certified fully capitated health plans. The Old Age, and to the Blind and Disabled and children in custody of the State's

Children's Services Division will be included in the OHP in 1995. Mental Health, Alcohol and Drug Services will be phased in beginning in 1995.

CONTACT: Joel Young, Associated Manager
Office of Medical Assistance
Managed Health Care United
500 Summer Street, NE
Salem, OR 97310
Phone (503) 945-6494
FAX (503) 373-7689

PENNSYLVANIA

Current Coordinated Care Programs

Health Maintenance Organizations (HMOs) and Federally Qualified Health Centers (FQHCs). Pennsylvania is committed to increasing the number of medical assistance recipients enrolled in managed care programs. We have agreements with six HMOs and one CHC. There are approximately 20 HMOs in Pennsylvania. We have an open invitation with the HMOs to negotiate agreements. Special efforts continue to be made to encourage HMOs to participate in Medicaid.

Most of the HMOs offer all of the benefits that are included in the Fee-for-Service (FFS) program. In most cases, these benefits are more comprehensive than the FFS system and the HMO's regular commercial packages. These services include, but are not limited to, office visits, hospitalization, inpatient and outpatient surgery, outpatient mental health, inpatient psychiatric, podiatry, eye exams, pharmaceuticals, and dental services. Clients in managed care programs do not have the expense of a copayment which is mandatory for those in our FFS Program. With managed copayment which is mandatory for those in our FFS Program. With managed care, the emphasis is on prevention, early detection, and continuity of care, resulting in lower hospital utilization and subsequent lower costs for the Department. There are approximately 171,659 medical assistance recipients enrolled in HMOs in Pennsylvania. There are approximately 1,458,486 medical assistance eligibles in Pennsylvania. Even though these numbers are low when compared to the total medical assistance caseload in Pennsylvania, they do represent progress. HMO enrollment continues to increase. Medical assistance recipients are not mandated to enroll in an HMO plan. HMO enrollment is on a voluntary basis. We are interested in increasing the number of medical assistance enrollments through HMOs which serve all income groups. Our current contracts are with:

- o Aetna Health Plan of Western Pennsylvania which provides services in Allegheny, Armstrong, Beaver, and

Westmoreland Counties;

- o Greater Atlantic Health Service which provides services in Bucks, Delaware, Montgomery, and Philadelphia Counties;
- o Keystone Health Plan East which provides services in Bucks, Delaware, Montgomery, and Philadelphia Counties;
- o FREEDOM, an Aetna Health Plan, which provides services in Berks, Lehigh, and Lancaster Counties;
- o Keystone Health Plan West which provides services in Allegheny County;
- o OakTree Health Plan provides services in Bucks, Montgomery, and Philadelphia Counties. They will begin marketing in mid-July 1993.

Federal regulations at 42 CFR 434.53, mandate the Commonwealth to establish a system of medical audits to ensure quality and accessible health care for medical assistance recipients enrolled in HMOs. An audit must be conducted at least once a year. The contractor conducts an onsite review of medical files, interviews HMO medical staff, reviews the quality assurance system, evaluates the quality of care and compiles a medical audit document.

Pennsylvania has an agreement with a Federally funded Community Health Center (CHC) to provide capitated medical services to approximately 4,053 medical assistance recipients in Dauphin County. The program has been in effect since November 1988. The major difference between the HMO contracts and the CHC contract is risk. The CHC cannot be at risk for inpatient hospital care. Providers must receive authorization for all non-emergency care and must verify the client's eligibility before services are given. The health center must be available to provide authorizations, conduct utilization reviews, educate its members and adjudicate claims. One of the major benefits to the program is dental care. The CHC is the only provider of some of the major dental services in a tri-county area.

On December 5, 1985, Pennsylvania received a waiver of specific provisions of Chapter 1902 of the Social Security Act to implement a primary care case management program. The program, currently known as HealthPASS, has been in continuous operation since March 1, 1986, in areas of South and West Philadelphia. HealthPASS is managed by Healthcare Management Alternatives, Inc. (HMA). HMA receives funds through a fixed rate prepaid capitation contract with the Department of Public Welfare (DPW) to pay for health services for medical assistance recipients in a designated area.

HealthPASS was created to reduce Medicaid expenditures while maintaining or improving the access to and quality of medical services. Unlike its FFS counterpart, in a managed care program such as HealthPASS, medical providers are paid for keeping their patients healthy. Recipients select a primary care physician (PCP) to act as their personal physician. PCPs provide or locate, as well as coordinate and monitor, all primary care and other medical care and rehabilitation services on behalf of their patients. Recipients have the freedom to choose their PCP, freedom to change their PCP at any time without cause, 24 hour telephone access to their PCP, access to a toll free 24 hour-a-day hotline maintained by the HealthPASS contractor, and freedom to enroll in an HMO serving the HealthPASS area. Recipients have access to a structured complaint and grievance system, and although not a waiver requirement, an extensive health education and outreach program assists and instructs recipients in accessing HealthPASS services.

All medical assistance recipients residing in Vine, West, Snyder, Delancey, and Federal districts of the Philadelphia County Assistance Office are covered by HealthPASS except monthly spend-downs, H-grants, State blind, recipients enrolled in HMOs, recipients of State mental hospitals, single point of contact recipients, and residents of long term care facilities and extended acute psychiatric care facilities. Current enrollment in HealthPASS exceeds 76,000 recipients.

HealthPASS recipients are entitled to receive all services provided by Pennsylvania's Medicaid Program. Although HMO services, private and public skilled or intermediate nursing facility services, funeral director services, transportation services other than by emergency ambulance to necessary medical care, outpatient drug and alcohol clinic services, outpatient psychiatric clinic and partial hospitalization services, and extended acute psychiatric care facility services are not the responsibility of HMA, recipients have access to these services through the traditional FFS program.

On December 28, 1992, the DPW submitted a request to the Health Care Financing Administration (HCFA) for approval of an amendment of the HealthPASS Program waiver. The approval to amend this waiver will extend services covered by HealthPASS to include psychiatric clinic, partial psychiatric hospitalization, methadone maintenance clinic, and drug and alcohol clinic services currently provided to HealthPASS enrollees through the FFS system. The amendment would also extend the geographic area serviced by HealthPASS to include the remainder of Philadelphia County, as well as Berks, Bucks, Chester, Delaware, and Montgomery Counties.

DPW's goal is to implement program changes effective July 1, 1994. To date, DPW has had no response from HCFA.

External assessments of HealthPASS are conducted on an ongoing basis. Beginning in December 1986, Birch and Davis Associates, Inc., evaluated access to care and assessed the quality of that care and the program's cost effectiveness as compared to the FFS program. On February 4, 1988, the final report detailing a medical review and evaluation of the quality of care delivered by HealthPASS was submitted by Health Assessment Associates (HAA). In March 1986, Chilton Research Services began a three phase study to assess Medical Assistance recipients' perceptions about HealthPASS compared to the FFS program. Under a three year contract effective January 1, 1990, through December 31, 1992, the Joint Commission of Accreditation of Healthcare Organization (JCAHO) evaluated the quality assurance program and conducted onsite medical record reviews of providers. JCAHO described HMA's quality assurance program as "State of the Art". In January 1987, SOLON Consulting Group, Ltd., began assessing access to HealthPASS services, quality of care, cost effectiveness, and the effectiveness of the case management function. SOLON's reassessment completed in September 1991 supports earlier findings showing that HealthPASS, through case management, has increased access to care, improved quality of care, and maintained cost effectiveness.

CONTACT: Margaret A. Williard, Acting Director
Bureau of Special Medical Assistance Programs
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 772-6300

RHODE ISLAND

Since 1972 the Rhode Island Department of Human Services has contracted with a Federally qualified HMO, the Harvard Community Health Plan (formerly RIGHA), to make prepaid medical care available on a voluntary basis to eligible recipients of the AFDC program. Amendments have been made in subsequent years to allow medically needy family groups and foster children to enroll. The contract provides for payment of a monthly premium not to exceed the cost of the FFS alternative. Participants are provided with a Harvard identification card as well as a Medical Assistance eligibility card, the latter to be used for services outside of the scope of services covered by Harvard.

Currently, Rhode Island is embarking on an ambitious initiative called RiTe Care designed to expand Medicaid eligibility for pregnant women and children under the age of six and to enroll

all AFDC-linked families in managed care during 1994. Each eligible person will be linked to a primary care provider responsible for coordinating all health care needs. The goals of Rite Care are to improve access and quality of care as well as to reduce the provision of unnecessary and duplicative services. Waivers are being prepared for submission and RFPs for managed care contractors will be issued later this year.

CONTACT: Robert J. Palumbo
Associate Director for Medical Services
Department of Human Services
600 New London Avenue
Cranston, RI 02920
(401) 464-3575

SOUTH CAROLINA

Current Coordinated Care Programs

South Carolina Managed Care Program,

Introduction. The South Carolina Managed Care Program was implemented effective February 1, 1990. The Managed Care Program is a joint effort between the State Health and Human Services Finance Commission (SHHSFC) and the South Carolina Department of Mental Health (SCDMH). Eight community mental health centers provide managed care services for Medicaid eligible recipients with a diagnosis of schizophrenia or affective disorder. The waiver was renewed for an additional two years effective August 1, 1992.

The goals of the program are to:

- o provide comprehensive medical and psychiatric care for the Medicaid population with severe mental illness;
- o improve access to quality, coordinated health care;
- o contain Medicaid costs for all health care by reducing inappropriate emergency room use, doctor shopping, inpatient admissions and duplication of services; and
- o prolong community tenure.

Provision of Services. The SHHSFC certifies providers (community mental health centers and primary care physicians) for participation in the managed care program. The SCDMH provides intensive case management and outpatient psychiatric services for a capitated rate through the community mental health centers.

The recruitment of primary care physicians/gatekeepers is a cooperative effort among SHHSFC, SCDMH and the community mental health centers. The appropriate staff explains the purpose of

the program and the role of the gatekeeper, and addresses provider concerns about Medicaid participation, submission of claims, reimbursement and patient compliance. Any physician wishing to serve as a gatekeeper agrees to provide 24 hour coverage and inform the client's case manager when authorizing treatment to a specialist or hospital and of failed appointments or problems related to compliance with treatment. The mental health case manager links each recipient to a primary care physician/gatekeeper who will treat, refer or authorize provision of necessary medical services, including emergency room use, hospital admissions and specialty care. The recipient's Medicaid card indicates the name and telephone number of the primary care physician. It is marked "restricted" and providers are asked to contact the gatekeeper for prior authorization of specialty, emergency room and inpatient care.

Criteria for Recipient Participation. Medicaid eligibles who meet all of the following criteria are eligible for participation: diagnosis of schizophrenia or affective disorder; not eligible for Medicare; not institutionalized or living in a residential care facility; and not enrolled concurrently in another case management program. There is a maximum of a 30:1 recipient to case manager ratio.

Program Evaluation. The Managed Care Program demonstrates the need for improved identification and coordination of total service needs for mentally ill patients among service providers; that intensive case management of the target population combined with smaller caseloads allows clinicians to effectively identify those medical and mental health needs which negatively affect the quality of life of the recipients; and that gatekeeper systems are most effective when States implement comprehensive utilization, monitoring and reporting system edits.

Preliminary evaluation results showed: 1) Thirty patients, 13% of those whose records were studied, were found to have previously undiagnosed medical conditions. Among these 30 recipients, 47 conditions were found, as some clients had multiple problems; 2) examination of each waiver recipient's psychiatric inpatient utilization five years prior to enrollment and at the end of 1992 showed inpatient admissions have been reduced by 57% and 3) providing the recipients with a medical home resulted in a 32% reduction in emergency room visits.

A final analysis of both mental health and medical care costs for the second and third waiver years will be performed in later 1993.

South Carolina Health Access Plan. The South Carolina Health Access Plan (SCHAP) was implemented effective February 1, 1993. This managed care national demonstration project is planned to

operate for three years in a two county area of the State. The project receives funding from the Federal Government (HCFA), the Duke Endowment, the AMA, and the State. As authorized by the enabling legislation and the program document, low income employees and their family members of qualifying small businesses are placed under primary care physicians for health maintenance supervision, with services being provided under the auspices of Medicaid. The employer pays the State portion of Medicaid match for his/her eligible employees and family members in the form of a monthly premium.

The goals of the program are to:

- o increase the number of employers offering insurance coverage and the number of persons covered
- o improve enrollee access to quality care
- o affect behavior by limiting use of emergency room services, unnecessary diagnostic testing, and inpatient hospitalization through the provision of managed care and more preventive services
- o improve efficiency and cost effectiveness of medical care and to lower cost
- o provide continuity of service to the demonstration participants
- o reduce provider bad debt and resultant cost increases to other payers
- o provide information which may be used in other areas in South Carolina and the U.S. to assess the feasibility and cost-effectiveness of using Medicaid as a vehicle of providing insurance coverage to low income employed workers.

Provision of Services: Once entered into the program, the member (recipient) selects a Primary Care Coordinator (PCC) from a group of Medicaid enrolled physicians who are included in the network. All care is either provided by the PCC, or arranged and approved by the PCC, to include after the fact approval of emergency care if required. Non-authorized care becomes the financial responsibility of the patient.

Non-covered Services: Where appropriate, patients will be moved into regular Medicaid programs when they become ineligible for the following non-covered services:

- o Pregnancy services, including prenatal care, delivery and post-partum services.
- o Neonatal, post-neonatal, and well child care for newborns.
- o Nursing home care and Community Long Term Care (CLTC) services
- o Organ transplantation and related services for adults.
- o End Stage Renal Disease (ERSD) dialysis and related

services

- o Institutional care, including psychiatric hospital, mental retardation facility, and alcohol abuse/chemical dependency facility services.
- o Residential treatment facilities, such as boarding homes and group homes, and other residential mental health treatment programs for adults and children.
- o Administrative days for members in acute care hospitals solely awaiting nursing home placement.
- o Health care and services where coverage by other State and Federal programs exists and/or is required.

Other than these limitations, other Medicaid services will be provided subject to the availability of identified funding and continued approval of the demonstration. Participant premiums have been established on an annual basis, using average Medicaid costing data with the above non-covered service cost removed.

Criteria for Recipient Participation: To participate, a business must have less than 100 employees, at least 50 percent of the employees must have adjusted family incomes of less than 150 percent of the Federal poverty level, at least three employees must desire to participate, the business must have not offered health insurance to this population within the past year, and the business must be located within Horry or Marion counties. Employees must meet the 150 percent of poverty criteria, have no other health insurance, be under the age of 65, be full time employees, and be a resident of South Carolina. Their eligibility status is re-evaluated on an annual basis.

Program Evaluation: The managed care program demonstrates a partnership between the Federal Government, the State Government, and the private sector in meeting the health needs of a large segment of our population through the expansion of the State Medicaid program. HCFA has contracted with an independent evaluator to perform the evaluation of this project. Action is ongoing both by the State staff and the designated contractor to learn from this effort. This project might well provide valuable insight into proper methodologies of dealing with the uninsured of small businesses.

Program Expansion: No expansion of the program is contemplated at this time.

Palmetto SeniorCare. Palmetto SeniorCare (PSC) is one of four operational replications of OnLok under Medicaid \$1115 and Medicare \$222 Demonstration waivers. PSC began operation under the waivers on October 1, 1990. OnLok is a risk-based, managed home care program in San Francisco for individuals with long term care needs. The program receives capitated Medicaid and Medicare payments. The OnLok/PACE demonstration waivers create joint Medicaid/Medicare capitated long term care programs for 10

projects that have been previously awarded grants by the Robert Wood Johnson Foundation pursuant to Section 9412 of P.L. 99-509. The goal of the demonstration is to consider the feasibility of risk based, long term care programs as viable options for Medicaid and Medicare.

The program serves individuals who are age 55 and older, live in Richland or Lexington county, meet the State long term care criteria, and are eligible for Medicaid and Medicare or willing to privately pay a premium equal to the combined Medicaid/Medicare capitated payment. Medicaid/Medicare eligible individuals who elect to participate in PSC waive traditional Medicaid/Medicare. Program participants who wish to return to the traditional Medicaid/Medicare system and who remain otherwise eligible, may do so with 30 days written notice. In return for the capitated payment, PSC assumes responsibility for the provision of all care. During the three year demonstration, the Medicaid and Medicare programs, through the State and Federal agencies, and PSC share in the financial risk through a complex risk sharing agreement. PSC will complete year three on September 30, 1993. Effective October 1, 1993, PSC will assume full risk. The demonstration will continue on yearly federal renewals.

Provision of Services. Eligible individuals who choose to participate in PSC waive traditional Medicaid and Medicare Services and agree to receive all health care through PSC. A care plan is developed in cooperation with the participant and his family/caregiver and continually monitored by the PSC multi-disciplinary team. The services are oriented toward primary and preventive care provided in a special day health center. PSC provides care directly through their medical staff of physicians, nurses, pharmacists, therapists, home care specialists and aides. Additional services are provided through staff social workers, nutritionist and transportation teams or through medical specialty contract. Hospital and/or nursing home care, if needed, are provided and reimbursed by PSC through contracts negotiated by the program with local facilities. Even though this is a long term care program, individuals whose functional level may improve to a level above the State long term care criteria, remain eligible for the program. Unlike traditional long term care programs, they are not disenrolled. Through constant monitoring of the participant in the day health and home setting, it is the goal of the program to minimize health care crises and maintain a more comfortable quality of life for persons in the final years of their lives.

Program Evaluation/Future Expansion. The Medicaid/Medicare waivers call for joint State/Federal monitoring visits to the program yearly. HCFA has also awarded the contract for the evaluation of the entire OnLok/PACE replication to ABT Associates, Inc. The evaluation design has been difficult to

lock down. HCFA is currently reviewing the most recent random design. The PSC program has begun preparing for an evaluation based on randomization. State evaluations will take place as the program progresses throughout the demonstration period. The State will carefully monitor the progress and viability of the program to determine if further expansion of the program in South Carolina will occur. The State will complete a client satisfaction survey during the summer of 1993 and explore other types of evaluations at the State level.

South Carolina High Risk Channeling Project (HRCP).

Introduction: The South Carolina High Risk Channeling Project (HRCP) was implemented in 1986 to address the problem of high infant mortality/morbidity rates which has plagued South Carolina.

The HRCP established the following goals:

- o To reduce the South Carolina perinatal mortality and morbidity rates;
- o To diminish the frequency and severity of handicaps associated with premature delivery and low birth weight and therefore reduce the need for long term care;
- o To decrease overall expenditures for maternal and newborn care; and,
- o To promote other specialized care for high risk pregnant women and infants.

Criteria for Recipient Participation: Participants in the HRCP must be Medicaid eligible pregnant women or newborns. The pregnant women must have a medical high risk factor such as hypertension, gestational diabetes, alcohol/drug addiction, documented by a physician on the SHHSFC's Pregnancy/Newborn Risk Assessment Form. The newborn must have a high risk factor (e.g. low birthweight) also documented on the Risk Assessment Form or be the newborn infant of a woman who was an HRCP participant.

Provision of Services. There are three essential elements of the HRCP: prenatal and intrapartum care furnished by a board certified/applied obstetrician; provision of ancillary services such as nursing, social work services, nutrition assessment; and delivery in level II or level III hospitals. The predominant method of service delivery is described as follows:

- o Prenatal care furnished in a HRCP clinic by an obstetrician working on a contractual basis or who is a direct employee of the clinic. Prenatal care may also be provided by a private HRCP physician;
- o Provision of case management services by a registered nurse or lay person who service as assistant case manager;
- o Nutrition assessment/follow-up provided by a registered

- o dietician;
- o Social work assessment/follow-up provided by a master's level social worker; and,
- o Delivery in a level II or level III hospital.

Evaluation. Extensive evaluation processes as used to measure HRCF's success in getting Medicaid recipients into care and assuring that they receive all necessary services. An independent evaluation is performed to assess the HRCF's impact in the areas of : a) patient access to services; b) quality of HRCF services; c) increase in number of pregnant women receiving prenatal care during the first trimester, d) automated tracking systems that includes patient assessment data, paid claims data, and results of quality assurance reviews; and e) cost effectiveness of services. The State has expanded its evaluation activities to include the following:

- o Development of evaluation pilots in appropriate counties to compare different approaches to facilitating high risk care;
- o Review of the medical aspects of the HRCF that will include, at minimum, an analysis of data/literature regarding "State of the art" risk appropriate care;
- o Review of the Pregnancy/Newborn risk Assessment tool to enhance its use as the point of entry to services for all Medicaid eligible pregnant women and infants.

The following outcome data is based upon FY 1991 evaluation activities:

Screenings;

- o Pregnancy screenings as percentage of pregnancy-ending hospitalizations: 115%
- o Channeled pregnancies as percentage of hospitalizations: 13%
- o Infant screenings as percentage of hospitalizations: 90%
- o Channeled infants as percentage of newborns: 6%
- o High Risk Channelings;
The percentage of Medicaid pregnancies channeled has risen from 11% in 1987-88 to 13% in 1990-91.
- o The percentage of infants channeled was 6% in 1990-91, an increase over previous years that probably reflects the improvement in the percentage of infants screened.
- o Place of Delivery;
Among Medicaid women residing in counties with only a Level I hospital, 77.5% of channeled women delivered at a Level II or III hospital, compared with 43.3% of non-channeled women.
- o Outcomes:
Percent of newborn claims with DRG 386 (extremely

immature or respiratory distress) fell from 3.2% in the first year of the HRCP to 2.0% in 1990.

Barriers identified that make outreach and enrollment difficult include:

- o Inadequate transportation
- o Inadequate number of Level II hospitals
- o Access problems associated with rural counties

Strategies developed to overcome barriers include:

- o Increased physician recruitment efforts;
- o Upgrading of Level I hospitals to allow Level II certification; and,
- o Increasing use of non-physician medical professionals (e.g. nurse practitioners) as service providers.

CONTACT: Robert A. Ehrlich, Department Head
Department of Delivery and Alternative Systems
1801 Main Street
Jefferson Square - 9th Floor
Columbia, SC 29201

SOUTH DAKOTA

PRIMARY DOCTOR PROGRAM

South Dakota received waiver approval to implement a PCCM program to begin 7/1/93. The project will begin in one pilot county and will incrementally move to become Statewide by 6/30/95. The PCCM includes mandating AFDC, AFDC low-income and SSI recipients to select a primary care physician, and this PCP will authorize/refer the following services:

- o inpatient/outpatient hospital care
- o general medical and surgery care
- o mental health/community mental health center services
- o podiatrist, ophthalmologist, chiropractor
- o medical equipment/prosthetic
- o prescription drugs
- o home health
- o residential/chemical dependency treatment

The program will continue the fee-for-service reimbursement that currently is used plus a case management fee of \$3.00 per recipient per month. Specific provider requirements include 24-hour access, referral/authorization of care, peer review of utilization, and monitoring referral care in the plan.

We also have a managed care program which determines medical

necessity of admissions, continued stays and discharges in exempt units of acute care hospitals which include neonatal, psychiatric, and rehabilitation. Field staff includes two care managers (RN's) who will work closely with the facility staff in discharge planning as an essential part of monitoring.

Our managed care efforts also include working with the Department of Health, on the following two programs which are currently in operation:

High risk pregnant women. All pregnant women are referred to DOH for a risk assessment to determine whether case management activities should be provided. DOH provides case management activities for those clients that are determined high risk and prepare and maintain a case record for each that includes:

- o prenatal risk assessment form;
- o workers primary responsibility with the client;
- o objectives of the management plan;
- o progress notes; and
- o pregnancy outcome report

Children with special health needs. DOH provides case management activities for children (age 0-21) with special health care needs and their families and prepare and maintain a case record for each that includes:

- o a written comprehensive assessment of child/family strengths and needs;
- o objectives of the care plan;
- o worker with primary responsibility for the child and family; and
- o progress notes

Another area of managed care consists of a program with Department of Human Services which includes managing individuals age 18 and older who are severely and persistently mentally ill. Services are to be Statewide and provided by, or supervised by, a qualified mental health professional and under the direction of a physician. The following case management services provided include:

- o client identification and outreach;
- o coordination of needs assessment;
- o development of a case management plan;

- o linking and monitoring with other agency services; and
- o referral and discharge planning

CONTACT: Donna L.C. Keeler
Department of Social Services
Office of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3495

TENNESSEE

Current Coordinated Care Programs

Tennessee Primary Care Network. The Tennessee Department of Health, Bureau of Medicaid, entered into a contractual agreement with the Tennessee Primary Care Network, Inc. (PCN) for the development and implementation of a HIO permitted by the waiver provision of the Consolidated Omnibus Budget Reconciliation Act of 1985. The HIO became a State defined HMO.

The HMO contracts with Medicaid for the provision of specified services on a prepaid capitation basis for AFDC eligible recipients in certain geographic areas of the State. The services include inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and emergency services.

Participation in the HMO, which is marketed under the title "Medicaid Plus", is voluntary. After joining Medicaid Plus, the AFDC recipient is restricted to those providers participating in Medicaid Plus. Referral to physician specialists and hospital services require the prior authorization of the participating primary care provider.

Medicaid Plus is itself not a provider of medical services and must subcontract with primary care providers for the delivery of health services to its members. Each participating provider has a panel of Medicaid recipients who have joined the project to whom the provider provides primary health care services and coordination of all necessary referrals. Any Tennessee Medicaid provider of primary health care services is eligible to subcontract with the HMO in a targeted area. Medicaid recipients who have joined Medicaid Plus will carry a pink Medicaid card clearly identifying them as project participants. The card will show the name and telephone number of the recipient's primary care provider. Provider claims for services rendered to Medicaid Plus participants will continue to be adjudicated by the Medicaid fiscal agent, but payment will be issued by Medicaid Plus.

The implementation of Medicaid Plus has taken place on an incremental basis. The first demonstration site was Monroe County on May 1, 1984, Davidson County was implemented on September 1, 1984, Shelby County on March 1, 1985, and then Hamilton County on January 1, 1987.

Effective November 1987, PCN, Inc. began marketing the following additional counties: Fayette, Cannon, Perry, McMinn, Robertson, Marion, Sumner, Claiborne, Wilson, Morgan, Coske, Bedford, Rutherford, Washington, Hancock, Campbell, Hamblen and Henry.

There are approximately 16,000 AFDC recipients enrolled in the program and expansion into other areas of the State will continue.

The cost effectiveness of this program is assured because the monthly prepaid capitation rate that is paid to PCN, Inc. cannot exceed 95 percent of the amount the Bureau would have expended to provide comparable services to a non-enrolled population.

CONTACT: Stephanie Anderson
Bureau of Medicaid
729 Church Street
Nashville, TN 37247-6501
(615) 741-0169

Pregnant Women Case Management Project. The target population for prenatal case management is defined as pregnant women who would be eligible for a Title V program.

The purpose of case management services for Medicaid eligible pregnant women is to:

- o assist these individuals in gaining access to needed medical, social and other services;
- o encourage the use of cost-effective medical care by referrals to appropriate providers;
- o discourage overutilization or duplication of costly services; and
- o reduce infant mortality and morbidity.

Case management is not the provision of medical care, but rather provides the necessary integration of non-medical services, such as nutrition, psychological, or health education/health promotion activities with ongoing medical care.

The services are provided on a statewide basis and providers must meet applicable State and Federal laws governing the

participation of providers in the Medicaid program and must have a referral agreement with the State Title V agency.

CONTACT: Melvin Everette
Bureau of Medicaid
729 Church Street
Nashville, TN 37247-6501
(615) 741-0221

Infants and Children to Age Two Case Management Project. The target population for infant and child case management services is defined as infants and children to age two who would be eligible for a Title V program. Services are provided in accordance with the Medicaid/Title V agreement throughout the State.

The purpose of case management services for infants and children is to:

- o assist these individuals in gaining access to needed medical, social, and other services;
- o encourage the use of cost-effective medical care by referrals to appropriate providers;
- o discourage overutilization or duplication of costly services; and
- o reduce infant mortality and morbidity.

The case manager should be a registered nurse or social counselor. The RN must be licensed in Tennessee and have one year experience in community health nursing. The social counselor must have a bachelor's degree in social or behavioral science with one year experience in a related position.

The case manager must have a referral agreement with the State Title V agency and must sign an agreement to meet all State child health standards.

CONTACT: Melvin Everette
Bureau of Medicaid
729 Church Street
Nashville, TN 37247-6501
(615) 741-0221

TEXAS

Texas implemented a Program of All-Inclusive Care for the Elderly (PACE) Waiver in February 1992. An 1115 Medicaid waiver and 222 Medicare waiver will enable Bienvivir Senior Health Services in El Paso to provide comprehensive health care services on a capitated basis to frail elderly individuals certifiable for

nursing facility care. This program is part of a national demonstration project to replicate the On Lok model piloted in San Francisco.

This program is based on a comprehensive care approach, providing an array of medical, functional, and day activity services for a capitated monthly fee that is below the cost of institutional care. Clients must be over age 55, qualify for Medicaid in a nursing facility and choose PACE services. The Texas Department of Human Services conducts periodic utilization and post-payment review. The project is a pilot at one site in El Paso that will give information on the possible application of the program to other sites in the State.

Bienvivir will transition into a fully capitated system over a two year period. It will operate under a Medicaid waiver only during the two year period, providing many health, social and restorative services for a capitated Medicaid payment while most acute medical services continue to be provided through the traditional Medicare and Medicaid systems. Beginning in the third year, Bienvivir will provide a comprehensive array of medical and social services for a monthly capitated fee from Medicaid and/or Medicare.

Although they are both capitated systems, PACE differs from a Social Health Maintenance Organization (S/HMO) because PACE concentrates on a high risk, frail population and uses an interdisciplinary team process to intensively manage risk at the individual client level. In contrast, a S/HMO manages risk actuarially by enrolling a range of well and frail individuals.

CONTACT: Anita Anderson
Texas Department of Human Services
P.O. Box 149030, M.C. W-521
Austin, TX 78714-9030
(512) 450-3195 or 450-3693

MEDICAID MANAGED CARE DEMONSTRATION PILOT

The Texas Department of Human Services is implementing an HMO model in Travis County on August 1, 1993. Texas has applied and received a 1915(b) waiver for this project which is called the LoneSTAR Health Initiative. The acronym STAR stands for the State of Texas Access Reform. Clients in Travis County will have a choice between a federally qualified HMO and a non-comprehensive PHP. Clients will select a participating physician who will act as the gatekeeper for their medical services. The federally qualified HMO is contracting with the FQHC in this county to act as a PCP and to continue to provide EPSDT and family planning services. Clients will maintain freedom-of-choice for emergency services, family planning and EPSDT services. The three prescription limit for the traditional

Medicaid program will be lifted to provide clients enrolled in this program with all medically necessary prescriptions. A new and extensive utilization management and quality assurance program will provide feedback to providers and tools for evaluating the project. The HMO model will be under total capitation. The PHP will be capitated for primary care services only.

A primary case management (PCCM) pilot implementation is planned for the late fall of 1993. Due to a reorganization of State government the project will transfer to the Texas Department of Health on September 1, 1993.

CONTACT: Linda K. Marstiller
Manager, Purchase Health Services
Texas Department of Human Services
PO Box 149030 y-927
Austin, TX 78714-9030

UTAH

Utah has operated a §1915(b) freedom of choice waiver since 1982. The program, called the Choice of Health Care Delivery (CHCD), is mandatory in the urban areas only, i.e., Weber, Davis, Salt Lake, and Utah Counties, and is optional in the remaining rural counties. In the urban areas, Medicaid recipients are asked to choose between an HMO (FHP and Blue Cross Blue Shield/MedUtah) or a variety of primary care physicians to manage their care. Once this choice is made, the provider's name is printed on the monthly medical card and the client must seek medical services through this "gatekeeper". If the services of a specialist are needed, written referrals to the specialist must be given by the primary care physician or the HMO must authorize the service before the service is rendered.

A unique feature of Utah's managed health care program is the employment of Health Program Representatives (HPRs) in the urban Human Services offices. The role of the HPRs is to explain the various health care options available and to assist the recipients and their families in making a health care choice that is best for them. The HPRs also function as health educators and help to inform clients about the responsible use of the medical card. Furthermore, they function as client advocates in assisting individuals in getting the health and social services that they need.

Effective July 1, 1990, Utah initiated a program to encourage recipients to utilize their primary care physicians instead of the emergency rooms. Recipients that seek routine care through the emergency rooms are redirected back to their primary care physicians, as identified on their medical cards, for these

services. Of course, urgent and emergent care are not effected by this policy. A payment of a \$20 triage fee is made to the emergency room physicians for their assessment.

Since January 1, 1990, we have been paying a case management fee to primary care physicians of \$2 per eligible per month. Effective July 1, 1991, the fee was discontinued for cost-effectiveness and budgetary reductions. We are still, however, requiring written referrals from the primary care physicians to specialist physicians. The referrals are matched with claims before specialist claims are paid.

All Medicaid eligibles, with the exception of long term care and certain foster care clients, are allowed to enroll in the CHCD program.

The Utah-Nevada Peer Review Organization has a contract with the State Medicaid Agency to perform external reviews of the medical services provided by HMOs.

CONTACT: Ed Furia, Gail Rapp, Zohreh Speckman or
Barbara Christensen
Utah Department of Health
Division of Health Care Financing
Bureau of Managed Health Care
288 North 1460 West
Salt Lake City, UT 84116
(801) 538-6123

Prepaid Mental Health Plan (PMHP). Utah's capitated PMHP is operating under the authority given by §1915(b)(2) (locality serving as a central broker) and §1915(b)(4) (restriction of recipients to specific providers.)

The purpose of the waiver is to counteract escalating costs, inadequate methods for assuring continuity of care, and a lack of provider accountability in controlling utilization rates. The State of Utah anticipates that the plan will slow the rate of increase in costs while improving access to services. In the present FFS payment system, prior authorization for inpatient psychiatric hospital services is required. However, a small but significant proportion of recipients utilize more than one psychiatrist and more than one hospital every year, raising overall costs significantly.

Access to emergency services and family planning services is not restricted under this waiver.

What is the Utah Medicaid Prepaid Mental Health Plan?

Program approved by the Health Care Financing Administration

under a 1915(b) (freedom-of-choice) waiver in which Medicaid eligibles in certain geographic areas of the State are required to obtain mental health services (inpatient and outpatient services) through the entity that has contracted with the State to provide such benefits.

What are the Covered Benefits?

Inpatient hospital psychiatric services and related physician services (excludes medical detoxification).

Mental health clinic and related physician services provided on and off clinic site (evaluation, psychological testing, individual and group therapy, medication management, day treatment).

Targeted case management for chronically mentally ill.

Which groups of Medicaid eligibles are enrolled?

All categorically and medically needy eligible groups are included. Only the recipients at the Utah State Hospital and Utah Developmental Center are excluded. Approximately 48,000 Medicaid eligibles are included in the plan, which represents about 50 percent of total Medicaid eligibles.

Who are the Contractors and How were They Selected?

An request for proposal (RFP) was issued in the Spring of 1990 requesting proposals from any entity that could provide the full range of covered services directly or through subcontract. Responses were received from six community mental health centers (CMHC) and one case management agency. Only the six CMHC met the RFP requirements. Negotiations were conducted with all six, but final agreements were reached with only three. Three-year contracts were signed and implemented beginning July 1, 1991 with the following entities:

<u>Contractor</u>	<u>Counties Served</u>	<u>FY '92 Monthly Enrollees</u>
Salt Lake Valley	2 urban	40,452
Four Corners	3 rural	3,008
Southwest Mental Health	5 rural	<u>4,132</u>
Total		47,592

What is the Payment Methodology for the Prepaid Mental Health Plan?

Contractors receive a combined premium each month for each enrolled Medicaid eligible who lives in the counties serviced by

the contractor. The premium is a combination of two rates: (1) inpatient hospital and related physician; and (2) mental health clinic including outpatient physician services.

Inpatient Hospital/Physician

Mental Health Clinic

Year 1 Risk - minimal, premiums set at 98% of upper payment limit with opportunity to adjust.

Non-risk - cost settlement based on audit & comparison of "shadow" claims.

Year 2 Risk - with stop-loss provisions.

Non-risk - cost settlement based on audit & comparison of "shadow" claims.

Year 3 Risk

Risk

How were the Rates Established?

Rates were established using calendar year 1989 Medicaid expenditures for covered services as the base year.

1. Medicaid expenditures for the base year were arrayed in a matrix including the following variables:
 - recipient county
 - 10 eligibility categories: AFDC 0-5, AFDC 6-20, AFDC adult; blind; disabled male & female; non-AFDC pregnant women; medically needy adult and child.

Category of services: (inpatient psychiatric service by ICD-9 diagnosis code; physician services by psychiatric CPT-4 codes and inpatient or outpatient; psychologist by procedure code; all mental health clinic including rehabilitation and case management.

2. The total expenditures for each category of eligible was then divided by total eligible months for each category of eligible by service and county to establish a rate per eligible month.
3. The following adjustments were made to establish an upper payment limit for FY '92:
 - inflation increase in rates to hospital, physicians, etc;
 - adjustment factor for increase in number of eligible months;
 - adjustment for increased utilization due to OBRA 1989 EPSDT mandates;
 - adjustment in utilization to account for lack of

historical data for two new clinic services (case management and rehabilitation) added to State Plan in 1988;

-adjustment for administrative cost to Medicaid agency.

4. The premiums for FY'92 contract year were set at 98% of upper-payment limit.

Any grievance or complaint can be first filed with the mental health plan's grievance system which is required by the contractor's agreement. If the recipient is not satisfied with the contractor's resolution of his complaint through the contractor's review process, grievances will then be reviewed by the State in the same manner as for non-waiver Medicaid recipients.

Case Management Program for Pregnant Women. The presumptive eligibility/enhanced prenatal services program has been in operation in Utah since 1986. Increased emphasis from Federal legislation stimulated a planning effort with the initial goal of raising awareness and increasing the number of pregnant women receiving appropriate services at an early stage of pregnancy. The ultimate goal was to reduce infant mortality and morbidity. The COBRA legislation of 1985 which provided for case management and enhanced services was used, along with the SOBRA legislation of 1986 which provided for presumptive eligibility determination.

Case management was developed as a very essential part of the prenatal program. The case manager for this program is known as the Perinatal Care Coordinator (PCC). This coordination process requires the knowledge and skill of a registered nurse or a certified social worker. The PCC serves as a liaison between clients and individuals or agencies involved in providing care, as a contact person for the client and family, and as a resource to prepare and counsel the client regarding essential services which are determined necessary and scheduled for the client.

The PCC is on the staff of the Qualified Provider (QP) of presumptive eligibility services or the private community physician who assumes care of the woman through her pregnancy. The intent is that the PCC become associated with the pregnant woman at the initial visit and begin at that point to assess her status and needs. The PCC plans and coordinates care and service to meet individual needs and to maximize access to necessary medical, social, nutritional, educational and other services for the pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

The perinatal care coordination process includes development of a comprehensive plan of service utilizing knowledge of alternative community resources to meet needs or resolve problems identified by provider assessments. Oversight tracking and monitoring of

services by the PCC is essential to minimize fragmentation of care, reduce barriers, link clients with appropriate services and assure that services are provided consistent with optimal prenatal care standards.

We do not anticipate any expansion in the PCC program.

The services of a PCC are available to any woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirements for presumptive eligibility to receive ambulatory prenatal care services provided by a provider who is eligible for payment under the State Plan.

Perinatal care coordination services are available statewide through qualified providers of presumptive eligibility services or private physicians.

There are no external reviews conducted in this program. Internal reviews are conducted from two different perspectives. First, the Utah Department of Health, Division of Family Health Services, manages this program operation. A program coordinator oversees activity by all qualified providers (including local health departments). Within the program operation there is a quality assurance audit and review. Second, Federally Qualified Community Health Centers are qualified providers in this program, and there is a quality assurance element within that organization.

The working relationship between Health Care Financing, Family Health Services and the Community Health Centers is such that we meet periodically to discuss issues, problems and proposed policy changes.

CONTACT: Urla Jeane Maxfield
Utah Department of Health
Division of Health Care Financing
P.O. Box 16580
Salt Lake City, UT 84116-0580
(801) 538-6149

VERMONT

Under the overall coordination of the Agency of Human Services, Vermont provides a number of programs which managed care services or include case management as a major component. The Department of Health is initiating the "Healthy Babies" program in October 1993. This is a voluntary program for pre-natal to one year of age and features a capitated, three-tiered bundle of primary care and case management services. The Department of Aging and Disabilities operates a Home and Community-Based Waiver program for elderly and disabled recipients eligible for ICF services.

Case management services are among the four categories of service provided by the waiver program.

Targeted case management services for the mentally ill and mentally retarded are provided by three programs operated by the Department of Mental Health. These programs contracted Statewide with community health centers to provide treatment planning, social support, service coordination, monitoring and advocacy.

The Department of Social Welfare, through its Medicaid Division, provides case management services through its "high tech" and out-of-state hospitalization management programs. The former is for children under 18 years old undergoing transition from an institution to home and consists of interdisciplinary coordination of health care services among providers. The latter is for recipients requiring out-of-state psychiatric, substance abuse, organ transplant and TBI services and provides case management services such as preadmission review, concurrent review, discharge planning and follow-up.

Three additional programs currently in development will provide either targeted case management or have case management components. The Department of Health is implementing "Part H" of the Education Act through a state-wide, voluntary program for children aged 0 - 3, 40% of whom will be Medicaid eligible. It will be a gateway integrating 16 components and features a capitated rate for provider networks. The Department of Social and Rehabilitation Services is designing a targeted case management program for children in its custody. A program for providing school health services for disabled, school-aged children who have written care plans (IEP or IFSP) is being implemented by the Department of Education in conjunction with the Agency of Human Services. It will include case management for medically necessary services.

Vermont does not have state-wide HMO coverage; as a result Medicaid does not have a paid capitated HMO program.

CONTACT: Kent Stoneman, Medicaid Director
Department of Social Welfare
103 South Main Street
Waterbury, VT 05671-1201
(802) 241-2880

VIRGINIA

The Virginia Department of Medical Assistance Services (DMAS) implemented MEDALLION, a primary care case management program (PCCM), effective January 1992. The program provides primary care for the ADC (Aid to Dependent Children) and ADC-related population of Virginia Medicaid recipients. With the successful

implementation of MEDALLION within four pilot areas throughout Virginia, the General Assembly mandated Statewide implementation beginning in January, 1993. The program is mandatory for Medicaid eligibles in operational areas.

MEDALLION. MEDALLION is a case management program for ADC and ADC-related Medicaid recipients. MEDALLION is designed to enhance access to primary care; provide for the continuity of care; promote the patient's compliance and responsibility when accessing medical care; promote the educational and preventative aspects of health care; and increase physician participation in the program.

All participants in the program are linked with a primary care physician (PCP) as a case manager, whose name and telephone number appear on each participant's entitlement card. The PCP approves all services covered by the waiver before they are rendered. Services under the waiver include physician services, prescription drugs, lab and x-ray, ambulatory surgery, and rural health center services.

The PCP is responsible for providing patient management for all covered services and agrees to provide or arrange coverage for services, consultation, or approval of referrals 24 hours a day, 7 days a week.

Reimbursement for services provided under the waiver are made using the existing fee-for-service basis. In addition to the FFS fees, MEDALLION offers participating providers a management fee of \$3 per patient per month for each enrolled client assigned to his/her practice.

Approximately 230,000 recipients are expected to participate in MEDALLION.

CONTACT: Thomas Bone, Director
Division of Alternative Health Care
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23226
(804) 371-2451

WASHINGTON

The Department of Social and Health Services (DSHS), Medical Assistance Administration (MAA), currently has six managed health care systems (MHCS) providing or arranging comprehensive medical services for eligible Medicaid clients. Current programs principally serve the categorically needy AFDC population. Programs in two areas of the State require mandatory enrollment under Federal waiver authority under 1915(b) of the Social Security Act and the remaining under voluntary enrollment. MAA

is currently expanding their programs to have most of the categorically needy AFDC population Statewide enrolled in managed care under a 1915(b) waiver. This expansion will include the two different service delivery models. MAA will contract with managed care organizations, through fully capitated, at risk plans. In addition, MAA will use a primary care case management (PCCM) model, contracting directly with service providers and paying a monthly case management fee to provide care coordination. The PCCM model will be used primarily in rural counties and with community and migrant health centers. Programs goals include increased access to primary care, contain rate of growth for program expenditures, promote more rational patterns of service utilization and ensure quality of care.

Current mandatory enrollment is approximately 32,000 recipients with an additional 4,000 in voluntary plans. An additional 250,000 to 300,000 will be added in 1993-94. Program expansion will also include other eligibility groups, focusing initially on children.

CONTACT: MaryAnne Lindeblad, Chief
Office of Managed Care
DSHS - Medical Assistance Administration
P.O. Box 45500
Olympia, WA 98504-5500
(206) 586-2583

DSHS has also received a demonstration grant from the Health Care Financing Administration to increase access to health care for people with incomes under 150 percent of the federal poverty level and not otherwise Medicaid eligible. MAA and the Washington Basic Health Plan (BHP) jointly planned, developed, and are operating managed care demonstration projects in Spokane County purchasing basic health coverage for the working poor and the unemployed who are without employee health insurance or Medicaid benefits. The project will also develop a partnership between the State and small businesses with fewer than 25 employees in purchasing health care for qualified individuals and families. Service delivery began in April 1993. The project, Health Access Spokane (HAD), will operate for three years and serve approximately 3,800 individuals when fully operational. The department, HAS and the BHP, will use the same two Medicaid managed care contractors in Spokane to deliver services.

CONTACT: Andy Renggli
Office of Recipient Services
DSHS - Medical Assistance Administration
P.O. Box 45530
Olympia, WA 98504-5530
(206) 586-2760

The Mental Health Division (MHD) has obtained a waiver under section 1915(b) of the Act. Under this waiver the State Mental Health Program will be administered through Prepaid Health Plans operated through individual Regional Support Networks. The effective date of the waiver is July 1, 1993 and the State is already negotiating contracts with two PHPs, who will commence providing services on September 1, 1993. All areas of the State will be covered by PHPs by June 30, 1995. Enrollment in the PHPs will be mandatory for all Medicaid eligibles in the State. During the initial phase of the waiver it will cover only outpatient mental health services. It is the intention of the MHD to phase-in the Voluntary Inpatient Psychiatric program as soon as possible during the first two years of the waiver.

CONTACT: Dave Dula
Mental Health Division
DSHS - Health and Rehab. Services
P.O. Box 45320
Olympia, WA 98504-5320
(206) 753-0911

WEST VIRGINIA

The West Virginia Physician Assured Access System is a statewide patient care system being developed by the Department of Health and Human Resources through its Office of Medical Services with the goals of:

- o assuring needed access to health care;
- o providing for the continuity of care;
- o preventing unnecessary utilization and cost; and
- o strengthening the patient/physician relationship.

As an enhancement to the West Virginia Medicaid Program, the system will provide recipients with a primary physician or family doctor who is responsible for providing or arranging the recipient's primary care and for referral for other medical services.

The following populations will be enrolled in the program and will be identified by a special medical card: Medicaid recipients receiving medical assistance under the AFDC or AFDC related categories, children in foster or subsidized adoption status, children eligible under Federal expansion programs and refugees. Excluded from participation are the following: aged, blind and disabled categories; SNF and ICF residents; mental hospital patients; and spenddown cases.

Physicians who may participate include general and family practitioners, pediatricians, obstetricians and gynecologists, internists, and physicians practicing in primary care centers or

clinics. Other physician specialists may participate under extraordinary circumstances with Departmental approval.

Recipients may select any participating primary care physician in practice in the recipient's county of residence or an immediately adjacent county. Recipients not selecting a primary physician will be assigned one. Recipients are free to change primary care physicians if they wish. Likewise, a physician may choose to disenroll a particular recipient.

The State of West Virginia has adopted a catchment area to include a 30-mile radius from participating providers. We have done this in lieu of constraining programs to county lines, in that many of the counties within the State have few providers, and many communities span county lines.

PAAS physicians, in addition to their normal FFS reimbursements from Medicaid, will be paid a monthly fee for each patient they manage.

PAAS providers must arrange for physician coverage 24 hours per day, seven days per week. The PAAS physician should inform the recipient of his or her normal office hours and explain the procedures the recipient should follow when the office is closed. The recipient must be able to contact the PAAS provider, or other medical practitioner designated by the PAAS physician, to receive necessary medical care. A 24 hour access telephone number will be printed on the recipient's medical assistance identification card. Anyone unable to reach the PAAS provider or the designated representative should contact the program staff as soon as possible.

The following service categories must be either provided or referred by the PAAS physician to be reimbursed by Medicaid:

- o Physicians, including EPSDT;
- o Hospital inpatient and outpatient;
- o Laboratory;
- o Home health;
- o Primary care and rural health clinic services; and
- o Ambulatory surgery.

Obstetrical care, including inpatient; family planning services, routine eye care by ophthalmologist or optometrist, psychiatric care including inpatient care in mental health centers and facilities, and other Medicaid covered services not included in the above list may be provided for the recipient without referral from the PAAS physician or prior authorization.

Referrals are made by the PAAS physician, in accordance with the accepted practices in the medical community, for specialty care or for primary care during his or her absence or non-availability. The PAAS physician must provide the specialist or

other physician with the numbers necessary for authorization and billing for the service.

The PAAS physician's referral to a specialist may be for consultation, consultation and treatment, or ongoing treatment of a chronic problem and is construed to include necessary diagnostic and treatment services. Time and other limitations may be imposed at the PAAS provider's discretion. The specialist must keep the PAAS physician apprised of the treatment and changes in the treatment plan. For billing purposes the specialist and provider of any related services must obtain and enter the PAAS provider's authorization number on medical claim forms.

If a recipient is an established patient of a specialist, the referral to that specialist should be made whenever applicable to the recipient's condition as determined by the PAAS physician.

"Emergency care" when delay in treatment may result in death or permanent impairment of health and "urgent care" which should not wait for a normal scheduled office visit do not require PAAS Pre-approval. However the PAAS physician should be contacted whenever practical to be advised that the care has been provided and to obtain authorization for billing. If an authorization cannot be obtained from the physician, the provider may contact the PAAS Unit for assistance.

Routine care in the emergency room is not to be authorized by the PAAS physician and will not be payable under the program except in underserved areas where the hospital has signed an agreement to provide backup service at an office visit rate. If the recipient demands routine care in an emergency room he/she must be advised that it will be provided on a private pay basis.

The program will be monitored to insure that recipients are able to access care and that utilization patterns and costs fall within acceptable standards. Included in the measures reviewed will be numbers of emergency room visits, specialty referrals, inpatient hospital admissions, prescriptions, office visits, and laboratory procedures. This review will be used to identify program irregularities as a basis for targeted provider/recipient education and for investigation of possible system abuse and corrective action.

The PAAS Advisory Committee functions as a subcommittee of the Medical Services Fund Advisory Council and has representation

from recipient advocacy groups and medical provider groups, and health-related State agencies.

CONTACT: Sue Thompson
Office of Medical Services
West Virginia Department of Health
and Human Resources
State Capitol Complex, Building 6
Charleston, WV 25305
(304) 926-1707

WISCONSIN

In 1984, Wisconsin began enrolling AFDC recipients residing in Dane and Milwaukee Counties into HMOs to receive their Medicaid services. The program was expanded to Eau Claire County in 1986. Wisconsin in FY 1993 contracts with 9 HMOs in these three counties to service 120,000 MA/AFDC recipients. Six of these HMOs are located in Milwaukee, two in Dane, and one in Eau Claire. In May 1993, there were 115,149 HMO enrollees in Milwaukee County, 3114 in Eau Claire County, and 2,338 in Dane County.

All AFDC recipients in Milwaukee County are mandatorily enrolled. In Dane and Eau Claire Counties, there is insufficient enrollment capacity to enroll all eligible recipients, therefore, in Dane County, all AFDC recipients residing in the City of Madison are required to join an HMO. In Eau Claire County, all AFDC recipients are currently either enrolled in an HMO or placed on an HMO waiting list until space becomes available.

The HMOs receive a fixed payment per person per month in exchange for providing and managing all of the MA services delivered to their MA enrollees. The MA enrollees receive all of their health care services from HMO providers, including inpatient and ambulatory services.

External review of the HMO Program are performed by the Wisconsin Peer Review Organization (WIPRO) and the Office of Policy and Budget, Evaluation Section.

WIPRO conducts annual medical chart reviews on 2% of all MA/HMO enrollees who use services. Through these reviews, WIPRO identifies potential cases in which inappropriate care may have been delivered and the Department of Health and Social Services (DHSS) conducts follow up on these cases. This process involves DHSS review of documentation submitted by the HMO and provider and, in some instances, corrective action by the HMO and provider.

The Office of Policy and Budget, Evaluation Section, conducts an evaluation of the HMO Program every two years. These evaluations cover HMO cost savings, the program's effects on utilization of services and other questions related to HMO grievances, quality assurance and accessibility. The earliest evaluations of the HMO Program (1984-86) were conducted by the Center for Health Policy and Program Evaluation.

An article entitled Mandatory HMO Care for Milwaukee's Poor by Rowland and Lyons from Health Affairs 1987, provides information on Wisconsin's HMO Program.

Since 1984, HMOs have saved over \$100 million in Medicaid dollars and are projected to save at least \$20 million during the next two years. Because the HMO Program has demonstrated success in containing costs and providing quality health care to enrollees, Wisconsin is continuing to explore HMO program expansion and other managed care options, including the following:

- o Wisconsin plans to implement a primary provider case management program in 1994 in selected counties. AFDC eligibles will have to pick a primary physician to coordinate their care or join an HMO that contracts with the MA Program. Plans are to enroll at least 60,000 eligibles by December, 1994.
- o Wisconsin is participating in the national OnLok replication project. Under this project the frail (nursing home eligible) elderly are enrolled into an HMO-like program which provides intensive case management to contain costs and improve participants' quality of life. If this program proves successful as a pilot project, it could lead to large scale enrollment of the frail elderly into similar programs in Wisconsin.
- o The High-Cost Case Management (HCM) is a program designed to reduce and control costs while improving access to appropriate medical services and enhancing the effectiveness of those services. The HCM would target Medicaid recipients with diagnoses indicating long-term, chronic illness accompanied by periodic episodes of inpatient or other intensive care needs (e.g., AIDS patients, severe head injury). Approximately 250 MA recipients, with selected high-cost diagnoses, whose annual health care costs exceed \$75,000 would be enrolled in a risk-based program. The Department is considering several payment models, including separate payment for case management services, or a risk-based capitation model for some or all services. Additional payment would be made for case management services. Participating providers

would coordinate appropriate care for these special needs cases.

- o Wisconsin is designing and implementing a prepaid research and demonstration program for providing coordinated medical and social services for disabled Medicaid recipients. The name of the project is Independent Care (I-Care). Work group members expect I-Care to have national significance as a prepaid program of care for the disabled and provide the basis for large-scale enrollment of the disabled into HMOs in Wisconsin. Wisconsin received a Health Care Financing Administration grant to support this initiative. Additionally, Wisconsin was one of three states to be awarded the consulting services of the Medicaid Working Group. The Medicaid Working group is funded by the Robert Wood Johnson Foundation and Pew Charitable Trusts to work with Medicaid programs to develop new systems of care for people with disability and chronic illness.
- o Wisconsin has begun discussing other managed care options which may be possible in other parts of the State and for other populations.

CONTACT: Neva J. Kaye
Department of Health and Social Services
Division of Health
One West Wilson Street
P.O. Box 309
Madison, WI 53701-0309
(608) 266-7677

WYOMING

Wyoming currently does not have any managed care programs in operation. We are considering a primary care case management initiatives and capitated arrangements with a hospital for primary care services.

CONTACT: Kenneth C. Kamis
Administrator
Division of Health Care Financing
6101 Yellowstone Road
Cheyenne, WY 82002
(307) 777-7531

PROPERTY OF
JAN 28 2000
HCFA LIBRARY

CMS LIBRARY



3 8095 00005243 7